VS A15 (4) 15M 9/5B

| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgom   |  |  | MA  | RYLAND                           | 2. USUAL RESIDENCE (\ STATE Virginia   | Vhere decease   | ba COUNTY  | ion: Resid                   |                           | re admiss                                      | sion)   |
|---|--|--|---|----------------------------------|--|---|--|------------------------------|---------------------------|--|---|
| b. CITY OR TOWN   | (If outside corporate limits   | s, write c   | LENGTH OF STA   | Y IN 1b                          | c. CITY OR TOWN (I   | outside carpo   |  |                              |                           | arest town                                     | 1)  |
| Betheso   | nearest tawn)  |  | 114 da  |                                  | Alexandr   |   | 8  | 24                           | 3                         |  |   |
| d. NAME OF HOS  | PITAL (If not in haspital, gi  | ve street odd  |   | <i>y</i> 10                      | d. STREET ADDRESS  | <u> </u>  | · · ·  |                              | Name of Street            | e. IS RES                                      | IDEN  |
| U. S. N   | aval Hospi   | tal  |   |                                  | 7139 Eve   | rglad   | es Driv  | 0                            |                           | YES [  |   |
| 3. NAME OF  | First  |  | Midd  | fle                              | Last   | 4. DATE   | Mor  |                              | Do                        |  | Yeor  |
| (Type or print)   | Ilon   |  | Benc  |                                  | ADAMS  | OF<br>DEATH   |  |                              |                           | 0  | 195   |
| 5. SEX  | 6. COLOR OR RACE   |  |   |                                  | DATE OF BIRTH  |   | 9. AGE (In years   | -                            | ER 1 YEAR                 |  | -   |
| Fomalo  | Caucasian  |  |   |                                  | 11-13-09   |   | lost birthdoy)<br>40 yrs.  | Manths                       |                           | Hours  | M   |
| Female 100. USUAL OCCUPA  | TION (Give kind of work de   | one 10b. KII   | ND OF BUSINESS  |                                  |  | te ar foreign o   |  | 12.0                         | ITIZEN OF                 | WHATC  | OUN   |
| during most af v  | vorking life, even if retired)   |  |   |                                  |  |   | ,,   | 1                            |                           |  |   |
| Journali  13. FATHER'S NAME   | .SU  | 146  | ewspape   | T.                               | Austr  |   |  |                              | U.S.                      | . A .  | -   |
|   | THOR OVO   |  |   |                                  |  | T TO STATE  |  |                              |                           |  |   |
|   | SENCZSKO<br>Ver in u. s. armed forc  | ES2 14 50  | CIAL SECURITY N   | IO IN                            | FORMANT  |   | Add  | rase                         |                           |  |   |
| (Yes, no, or unknown)   | (If yes, give war or dates of ser  |  | CIAL SECORITI   |                                  |  | 1.20  |  |                              | . 40                      | - h -  |   |
| NO  | 1  |  |   | (H)                              | Harold W   | . Ada   | ms, sam  | e as                         | 3 #2                      | abc  | ve  |
| IB. CAUSE OF  | DEATH [Enter only one cau  | se per line l  | for (o), (b), and (   | c).]                             |  |   | 7 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |                              |                           | ERVAL BE                                       |   |
| PART I. C   | EATH WAS CAUSED BY:  | F.L.   |   | -                                |  |   | PE .   |                              | Olys                      | EL VIAD  | DEM   |
| 1000  | IMMEDIATE CAUSE (o)  |  |   |                                  |  | 17. 6   |  |                              |                           |  |   |
|   | mine chose (o)   |  | 0019  | 210-                             | ma mu  | 1+16  | -orme  |                              | 1                         | 42   | 2   |
| 1777,7  | DUE TO   | ВП   | 00193   | -19-                             | ma mu  | Itif  | orme   |                              | /                         | 42   | a i   |
| Conditions if   | DUE TO   | יונק   | 00191   | C12-                             | ma mu  | Itif  | -orme  |                              | /                         | 42   | a.  |
| Conditions, it  | DUE TO ony, which (b)  | ДП   | 00191   | (10-                             | ma mu  | Itif  | orme   |                              | /                         | 42   | a   |
| Conditions, it gove rise to cause (o), stati  | DUE TO ony, which (b)  | БП   | 00 191  | -613                             | ma mu  | Itif  | orme   |                              | /                         | 42   | · ·   |
| gove rise to  | DUE TO  ony, which immediate and the under-  | יוק  | 00141   | (13-                             | ma mu  | Itif  | orme   |                              | /                         | 42   | · ·   |
| gove rise to<br>cause (o), stati<br>lying cause lo  | ony, which immediate DUE TO  DUE TO  DUE TO  | DITIONS CON  | NTRIBUTING TO D   | DEATH BUT I                      | NOT RELATED TO THE TER   | MINAL DISEAS  | SE CONDITION GIV   | VEN IN P                     | ART 1(a) 1                | 9. WAS   | AUTO  |
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| gove rise to cause (o), statilying cause lo  PART II. (  200. ACCIDENT OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION Hour o. r p. r  21. I certify alive anS  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W  220. BURIAL, CREMA  | DUE TO  ony, which immediate ng the under- st.  OTHER SIGNIFICANT COND  WAS UNDERLYING  NG CAUSE OF DEATH FY MEDICAL EXAMINER)  URY Manth, Day, Year n. 19  that I attended the sept. 18  H. DRUCKEM   | 20d. INJU<br>While<br>of work [<br>deceased<br>, 19 59                   | BE HOW INJURY  URY OCCURRED  Not while of wark  I from May  , and the               | 20e. PLA fact 27 at death        | CE OF INJURY (Hame, for ary, street, affice bldg., coccurred at 0.35   | ept.  Port I ar Pai  ept.  PM, fram  Address (s  Nava.) | rt II of item 18.)  y or town)  18 , 159  the causes ar street, city or town,  1 Hospi   | ,that I and an t stote) tal  | (County)<br>last sav      | 9. WAS PERFO                                   | AUTCERME NO                                     |
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| gove rise to cause (o), stati lying cause lo  PART II. (  PART II. (  OR CONTRIBUTI (IF EITHER, NOTI  20c. TIME OF IN. Hour o. r  P. r  21. I certify alive an  ACTUAL SIGNATURE (  PHYSICIAN'S WAME (Type) W  220. BEMOVAL (Spec   | DUE TO  ony, which immediate age the under- st. (c).  DTHER SIGNIFICANT COND  WAS UNDERLYING CAUSE OF DEATH FY MEDICAL EXAMINER)  URY Manth, Day, Year 19  that I attended the ept. 18  H. DRUCKEM.  H. DRUCKEM.   | 20d. INJU<br>While<br>of work [<br>deceased<br>, 19 59                   | JRY OCCURRED Not while of wark  from May  , and the                                 | 20e. PLA fact 27 at death MC, US | CE OF INJURY (Hame, for any, street, affice bldg., street, affice bldg., street, affice at 035 occurred at 035 | ept.  PM, fram ADDRESS (S Nava.  22d. LOCA PT1          | y or town)  18 , 159 the causes are street, city or town,  1 Hospi  Marylan  TION (City, town,   | tal                          | (County) last sav he date | 9. WAS PERFC YES XX  v the destated DAT  (Stol | AUTORME (NO                                     |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10094

|               |   |                                   | 103                                      | 40               | CER                         | RTIFICA    | ATE OF                       | DEATH                         | 1                      |              |                       | Reg. Di         |            | UU       | (A) (A)           |
|---------------|---|-----------------------------------|--|------------------|-----------------------------|------------|------------------------------|-------------------------------|------------------------|--------------|-----------------------|-----------------|------------|----------|-------------------|
| 1             |   | mery                              |  |                  |                             | ARYLAND    | 2. USUAL RES<br>O. STATE     | YAn                           | 1                      | b. (         | Man                   | rtge            | mei        | ey       |                   |
| 7             | B. CITY OR JOWN RURAL ond give                          | (If outside coneorest town)  PARK | rporate limit                            | s, write         | 3 days                      | If Is      | TAKO                         | TOWN (If o                    | Pak                    | rate limits  | , write RL            | JRAIL ond       | give nea   | est town | 1)                |
| 4             | d. NAME OF HOSP<br>OR INSTITUTION                       | ITAL (If not in                   | San i                                    | ve street        | HOSP,                       |            | d. STREET                    | FORS                          | ton                    | DR           | . /                   |                 |            |          | FARM?             |
|               | NAME OF<br>DECEASED<br>(Type or print)                  | 1                                 | PARY                                     | t                | GARdi                       | ner.       | A: Ke.                       | n<br>n                        | 4. DATE<br>OF<br>DEATH |              | Mont<br>9             | h               | Da:        |          | Year<br>1959      |
| 4             | fe  | w                                 | OR RACE                                  | 7. MARR          | D DIVO                      | ORCED 🔲    | B. DATE OF BIR               | -10 -                         | -99                    | 60           | In years rthdoy) yrs. | Months          | Days       | Hours    | Min.              |
|               | USUAL OCCUPAT<br>during most of wo                      | rking life, ev                    | nd of work d<br>en if retired)<br>graphe |                  | S GOV                       |            | STRY 11. BIRTHE              | PLACE (Stole                  | ar fareign c           | ountry)      |                       | 12. CI          | MEN O      | F WHAT   | COUNTRY           |
| 13.           | Villiam   | H. 1                              | Metz                                     | ler              |                             |            | EVA                          | S MAIDEN N                    | 2                      | I/AI         | 7                     |                 |            |          |                   |
| 15.<br>(Ye    | was deceased ev<br>s. no. or unknown!                   | ER IN U. S. /                     | ARMED FORCE<br>or or dates of se         | rvice            | SOCIAL SECURITY<br>04-14-92 | 1 1        | Pts ho                       | 50, 1                         | Rece                   | Rd           | Addr                  | ess             |            |          |                   |
|               | 18. CAUSE OF DE   | ATH [Enter                        |  | se per lir       | e for (o), (b), and         | (c).]      | 0.                           | 0                             | ,                      | 0            |                       |                 | INTE       | RVAL BE  | TWEEN             |
| 9             | 420.1   | IMMEDIAT                          | E CAUSE (o)                              |                  | · ·                         | 0          | ala                          | 0                             | 700                    |              | 0                     | ^               |            |          |                   |
| N             | Conditions, if  |                                   | ) (b)                                    | a                | terro                       | ode        | rolic                        | Coro                          | wasy (                 | wfe          | y Do                  | ela             | e          |          |                   |
|               | gove rise to<br>couse (o), stating<br>lying couse lost  | the under-                        | DUE TO (c)                               |                  |                             |            |                              |                               | 0                      |              | -1                    |                 |            |          |                   |
| CERTIFICATION | PART II. O  | THER SIGNIFI                      | CANT CONE                                | OITIONS C        | ONTRIBUTING TO              | DEATH BUT  | NOT RELATED TO               | O THE TERMI                   | NAL DISEAS             | E CONDIT     | ION GIVI              | EN IN PAI       | RT 1(o) 19 | PERFC    | AUTOPSY<br>PRMED? |
|               | 20a. ACCIDENT W<br>OR CONTRIBUTING<br>(IF EITHER, NOTIF | G CAUSE                           | OF DEATH                                 | 20b. DESC        | RIBE HOW INJUI              | RY OCCURRE | D. (Enter noture             | of injury in F                | Port I or Pari         | t II of item | n 18.)                |                 |            |          |                   |
| MEDICAL       | 20c. TIME OF INJU<br>Hour o. m.<br>p. m.                | RY Month,                         | Day, Yea                                 | While<br>of work | Not while of work           | 20e. PL    | ACE OF INJURY street, office | (Home, form<br>ce bldg., etc. | , 20f. (City           | or town)     |                       | (               | County)    |          | (Stote)           |
| -             | 21. I certify t   | hat I atte                        | nded the                                 | decease          | 4                           | clob       | 195                          | 7.10_                         | ept                    | -11,         | 19_55                 | that I          | last sa    | w the    | deceased          |
|               | alive on  | Jegy                              | 0  | ., 19            | , and t                     | hat death  | occurred at                  |                               | M, fron                |              |                       |                 | he dat     |          | ed above          |
|               | ACTUAL SIGNATURE  | yes                               | Rab                                      | ken              |                             |            | M.D [ 0                      | 19 le                         | moder                  | ty           | Zoule                 | roll            | 6.26       | 9        | 112/0             |
|               | PHYSICIAN'S B   | ORIS                              | 6  | AI               | 3KIN                        |            | Si                           | lves                          | Syr                    | ing          | 1                     | enl.            | g of       | 17       | 7-3               |
| 22c           | REMOVAL (Specify<br>ANS. & BU                           | 1                                 | 9/15/                                    |                  | 22c. NAME OF                |            | R CREMATORY LLEY CEN         | /ETED V                       | 220 LOCAT              | NVIL         |                       | r county) PENNS | SVIV       | (Stot    | e)                |
| 23            | FUNERAL DIRECTOR RAYMOND                                | PUMPH!                            | EY, I                                    | NC.              | STLVER                      |            | G, MD.                       |                               | BY REGIST              | RAR 24       | b. REGIS              | TRAR'S SI       | GNATUR     | E        |                   |

may be retained to TO FUNERAL DIV page 3 shauld be the registrar prior t TO HOSPITAL OR VS A15 (4) 15M 10/57

|  | CERTIFICATE OF DEATH   | District on the second   |
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

death. Page 4

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10378 CERTIFICATE OF DEATH

**CERTIFICATE OF DEATH** 

10325

Reg. Dist. No.

| 1. PLACE OF DEATH<br>a. COUNTY             |   |                                   |            | USUAL RESIDENCE (WI                              | here deceased          | l lived. If instituti     | on: Residence | before admis | sion)                |
|--|---|-----------------------------------|------------|--|------------------------|---------------------------|---------------|--------------|----------------------|
| MONTGOME                                   | RY  | MARYL                             | LAND       | MARYLANI   | D                      |                           | GOMERY        |              |                      |
| b. CITY OR TOWN (<br>RURAL ond give n      | If outside corporate limits, wr<br>earest town)                 | c. LENGTH OF STAY I               | IN 1b      | c. CITY OR TOWN (If o                            | outside corpo          |                           |               | nearest low  | n)                   |
| OLNEY                                      |   | 4 DAYS                            |            | GAITHERS   | SBURG                  | R.F.                      | D.            | # 2          |                      |
| OR INSTITUTION                             | TAL (If not in hospital, give st                                |                                   |            | d. STREET ADDRESS                                |                        |                           |               | ON           | SIDENCE<br>FARM?     |
|  | COUNTY GENER  |                                   | INC        |  |                        |                           |               | YES          | NOXX                 |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First LABAN   | Middle B 0 G                      | 400        | ARMSTRONG  | 4. DATE<br>OF<br>DEATH | Man                       | th<br>TEMBER  | Doy<br>29    | Year<br>19 <b>59</b> |
| S. SEX                                     |   | MARRIED NEVER MARRIE              | DET RE     | ATE OF BIRTH                                     |                        | 9. AGE (In years          |               | EAR IF UND   |                      |
| MALE                                       | WID   | OWED WY DIVORCED                  |            | 12/21/72   |                        | last birthdoy)<br>86 yrs. |               | ays Hours    | Min.                 |
| 10a. USUAL OCCUPATION                      | ON (Give kind of work done                                      | 777                               | P INDUSTRY |  | or foreign co          |                           | 12 CITIZE     | N OF WHAT    | COUNTE               |
| Retired                                    | king life, even if refired)                                     |                                   |            |  |                        | ,,                        |               |              | COUNTR               |
| 13. FATHER'S NAME                          | Farmer  | Own Farm                          | - 1,       | 4. MOTHER'S MAIDEN N                             |                        |                           | USA           | 1            |                      |
| 13. TATTIER 3 NAME                         |   |                                   |            | 4. MOTHER 5 MAIDEN P                             | AWWE                   |                           |               |              |                      |
|  | ARMSTRONG   |                                   |            | JANE DAVI  | S                      |                           |               |              |                      |
| (Yes, no. or unknown)                      | R IN U. S. ARMED FORCES? (If yes, give wor or dates of service) | 16. SOCIAL SECURITY NO.           | 17. INFO   | RMANT  |                        | Add                       | ress          | ,            |                      |
| No   |   | No                                | Ho         | SPITAL RECOI                                     | RDS                    | 0                         | LNEY.         | In.          |                      |
| 18. CAUSE OF DEA                           | ATH [Enter only one couse p                                     | per line for (o), (b), and (c), i |            | ^  |                        | . ,                       |               | INTERVAL BI  | TWEEN                |
|  | TH WAS CAUSED BY:   |                                   |            | 80: 7  | 11                     | - +11.                    |               | ONSET AND    |                      |
|  | IMMEDIATE CAUSE (a)   | (in mi                            | 15         | Joles  | C 1                    | cay pur                   | nong          | 100          | 24/                  |
| 14-20.0                                    | DUE TO  |                                   |            | 0 1  |                        |                           | 1             | ,            |                      |
| Conditions, if o                           | ny which )  | Conto                             |            | La la  | 0.                     | 11 (2.18)                 |               | HI           | Ja                   |
| gove rise to i                             | mmediate  | - W                               | M          | o which  | 1                      | <u> </u>                  |               | 1/           |                      |
| couse (o), stoting                         | the under-  |                                   |            |  |                        |                           |               | /            |                      |
| lying cause lost.                          | ) (c)   |                                   |            |  |                        |                           |               |              |                      |
| PART II. OTI                               | HER SIGNIFICANT CONDITIO  | ONS CONTRIBUTING TO DEA           | TH BUT NO  | T RELATED TO THE TERM                            | INAL DISEASE           | CONDITION GIV             | EN IN PART 1  | (o) 19. WAS  | AUTOPSY              |
| 3  |   |                                   |            |  |                        |                           |               |              | NO NO                |
| 20a. ACCIDENT WA                           | AS UNDERLYING   20b.  CAUSE OF DEATH MEDICAL EXAMINER)          | DESCRIBE HOW INJURY OC            | CURRED. (I | inter noture of injury in I                      | Port I or Port         | II of item 18.)           |               |              | Les                  |
| 5 [  |   |                                   |            |  |                        |                           |               |              |                      |
| 20c. TIME OF INJUR                         |   |                                   | 20e. PLACE | OF INJURY (Home, farm, street, office bldg., etc | n, 20f. (City          | or tawn)                  | (Cou          | inty)        | (State)              |
| Hour o.m.                                  |   | /hile Not while work of work      |            | , moon, onnee brogn, ene                         | 1 /                    |                           |               |              |                      |
|  |   | 11 (7/2                           | 47         | 10 16.   | 9/20                   | 15                        | 6             |              |                      |
| 01   | not I oftended the dec  | eosed from.                       |            | 19.00 710  | -1-1-K-1               | 19_0                      | 7, that I los | st saw the   | deceos               |
| alive on_7_/                               | 67/   | 1257_, and that                   | deoth oc   | curred of 8:05/                                  | AM, from               | the couses of             | nd on the     | date stot    | ed abo               |
| /  | (Inhan'   |                                   |            | 0  | ADDRESS IST            | reet, city or town,       | stote)        | / D.         | ATE SIGN             |
| ACTUAL                                     | WYVY2   |                                   |            | X and  | - XK                   | M                         | 1/            | 9/2          | 9/1                  |
| SIGNATURE                                  | X   |                                   | M.D        | · · · · · · · · · · · · · · · · · · ·            | TAYU                   | 7                         |               |              | 4                    |
| PHYSICIAN'S<br>NAME (Type)                 | I M Pinn  | м р                               |            |  |                        | M                         |               | / /          |                      |
|  | J. W. BIRD  |                                   |            |  |                        | ING. MAR                  |               |              |                      |
| 220. BURIAL, CREMATIO<br>REMOVAL (Specify) |   | 22c. NAME OF CEME                 |            | REMATORY   | 22d. LOCAT             | ION (City, town,          | or county)    | (Sta         | le)                  |
| Burial                                     | Oct. 1  | 59 Rockvil                        | le         |  | Ro                     | ckville                   |               | Md           | 2 17-0               |
| 23. FUNERAL DIRECTOR                       | S SIGNATURE   | ADDRESS                           | 7.0        |  | D BY REGIST            | RAR 24b. REGIS            | STRAR'S SIGN  | ATURE        |                      |
| oray w-                                    | - Warber  | Laytonsvil                        | те         | Md. DATE OF                                      | CT 2'5                 | 9 6                       | illus D. T    | hous.        |                      |

TO HOSPITAL OR VS A1S (4) 1SM 10/S7

DESIGNATE OF DEATH THE PARTY OF THE P N

VS A15 (4) 15M 10/57

| MARYLAND | STATE DEPA | RTMENT OF | HEALTH-B | ALTIMORE, | 18 |
|----------|------------|-----------|----------|-----------|----|
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10326

Reg. Dist. No.

| 1 | 1. [    | PLACE OF DEATH   | 1001  | 3       | MARYL                | AND     | 2. USUAL RESIDENCE (W          |  | d lived. If institution  | n: Residence | before   | admission)                |
|---|---------|--|---|---------|----------------------|---------|--------------------------------|--|--|--------------|----------|---------------------------|
| 1 |         | Montgomer  | outside corporate limits,                                 | write   | c. LENGTH OF STAY IN |         | e. CITY OR TOWN (IF            |  | vote limits, write Pl  | IPAL and air | o neare  | st town\                  |
|   |         | RURAL ond give ne  | orest town)   |         |                      |         |                                |  | 10   | 2 x ==       | a neare  |                           |
|   | -       | d. NAME OF HOSPITA   | AL (If not in hospital, give                              | street  | 11 days              |         | d. STREET ADDRESS              | 100  | 97   |              | e.       | IS RESIDENCE              |
| 0 |         | OR INSTITUTION   | cal Center.   | Ret     | boada II. I          | W.A     | Box 635                        |  |  |              |          | ON A FARM?                |
|   | 3. 1    | NAME OF  | First   | Der     | Middle               | VILLE   | Lost                           | 4. DATE  | Mont   |              | Day      | Year                      |
|   |         | DECEASED<br>(Type or print)                                | Frank   | 277     | Caroly               | n       | Awbrev                         | OF<br>DEATH  |  |              | l.       | 19 59                     |
|   | 5. S    | SEX  |   |         | IED NEVER MARRIED    |         | . DATE OF BIRTH                |  | 9. AGE (In years last birthday)  |              | YEAR IF  | UNDER 24 HRS.             |
|   |         | Female   |   | IDOWE   |                      |         | eptember 22.                   | 1946   | lost birthday)   | Months E     | oys I    | Hours Min.                |
|   | 10a     | . USUAL OCCUPATIO  | N (Give kind of work dor                                  | ne 10b. | KIND OF BUSINESS OR  |         | RY 11. BIRTHPLACE (Stole       |  | The same of the sa | 12. CITIZ    | EN OF    | WHAT COUNTRY?             |
|   |         | Student  | ing life, even if retired)                                |         | None                 |         |                                | Texas  |  |              | II.      | S.A.                      |
|   | 13.     | FATHER'S NAME  |   |         | 110110               |         | 14. MOTHER'S MAIDEN I          | The Part of the last of the la |  |              | 0 01     | J 612 6                   |
| ) |         | Frank I.   | Awhrev  |         |                      |         | Bertha Gil                     | more   |  |              |          |                           |
|   | 15.     | WAS DECEASED EVER  | IN U. S. ARMED FORCE                                      |         | SOCIAL SECURITY NO.  | 17. IN  |                                |  | RecordAddr   | ess          |          |                           |
|   | fier    | No   | If yes, give war or dates of servi                        | (e)     | None                 | Th      | e Clinical C                   |  |  |              | Mary     | vland                     |
|   |         |  | TH [Enter anly one couse                                  | per lin |                      |         |                                |  |  |              | INTER    | VAL BETWEEN               |
|   |         | PART I. DEAT   | TH WAS CAUSED BY: IMMEDIATE CAUSE (a)                     | Int     | racerebella          | r He    | morrhage                       |  |  |              | 3        | hours                     |
|   |         | 2043   | DUE TO  |         |                      | FIE     |                                |  |  |              |          |                           |
|   | П       | Conditions, if or  |   | Acu     | te Myelogen          | ous     | Leukemia                       |  |  |              | 3        | weeks                     |
|   |         | gave rise to in<br>couse (a), stoting t                    |   |         |                      |         |                                | 5 or it  |  |              |          |                           |
|   |         | lying cause last.  | (c)_  |         |                      |         | Renal Infan                    |  |  |              |          |                           |
| 6 | CATION  | PART II. OTH   | ER SIGNIFICANT CONDIT                                     | TIONS C | ONTRIBUTING TO DEAT  | H BUT N | NOT RELATED TO THE TERM        | INAL DISEAS  | E CONDITION GIVE   | N IN PART    | l(o) 19. | WAS AUTOPSY<br>PERFORMED? |
| - | CAI     |  | tasis of Lun  |         |                      |         |                                |  |  |              |          | ES NO                     |
|   | CERTIF  | 20g. ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | S UNDERLYING [] 20<br>CAUSE OF DEATH<br>MEDICAL EXAMINER) | b. DESC | CRIBE HOW INJURY OCC | CURRED  | (Enter nature of injury in     | Port I or Por  | t II of item 18.)  |              |          |                           |
|   | CAL     | 20c. TIME OF INJURY  | Month, Day, Year  | 20d. IN | JURY OCCURRED 2      | Oe. PLA | CE OF INJURY (Home, form       | n, 20f. (City  | y or town)   | {Co          | unty)    | (State)                   |
|   | MEDICAL | Hour o.m.<br>p. m.   | 19  | While   | Not while            | foct    | ory, street, affice bldg., etc | .)   |  |              |          |                           |
|   |         |  | at I attended the d                                       |         |                      | t. 21   | . , 19.59 , to Se              | ntembe   | ar li 10 59  | Ab mA I I m  |          | 45 - 4                    |
|   |         | alive on Sept  |   |         |                      |         | accurred at 7:15               |  |  |              |          |                           |
|   |         | unive uni  | -0  | ·       | y, and mare          | acom.   |                                |  | treet, city or town,   |              | uore     | DATE SIGNED               |
|   |         | ACTUAL SIGNATURE   | aurence 1   | C.      | Housdon)             |         | The Clinic                     |  |  |              | 9/4      | /59                       |
| 1 |         |  |   | 1       |                      |         | National ]                     |  |  | ealth        |          |                           |
| Н |         | PHYSICIAN'S I  | WRENCE A. C   | AYD     | OS, M.D.             |         | Bethesda 1                     |  |  |              |          |                           |
|   | 220     |  | N, 226. DATE THEREOF                                      |         | 22c. NAME OF CEMET   | ERY OR  |                                |  | TION (City, town, o  | r county)    |          | (Stote)                   |
| , | 5/      | REMOVAL (Specify)  | 19-4-59   |         |                      |         |                                | KL   | =RMI   | Ti           | TE       | XAS                       |
|   | 23.     | FUNERAL DIRECTOR'S   | SIGNATURE   | 1       | ADDRESS              | 0       | 240. REG                       | D BY REGIST  |  | TRAR'S SIGN  | NATURE   |                           |
|   | - 2     | vu Ci  | rambers   | 6       | 1400 0               | rep     | in I pare                      | SEP  | 8 '59  | arthur       | & the    | aud                       |

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ofter death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

TO FUNERAL D

VS A15 (4) 1SM 10/S7

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

|   | MARYL   | AND ST                           | TATE DEPA            | ARTM      | ENT OF HEALT  | H-BAL                  | TIMORE, 1                            |                   | 4 () 0        | O.I.                    |
|---|---|----------------------------------|----------------------|-----------|---|------------------------|--------------------------------------|-------------------|---------------|-------------------------|
|   | 103   | 41                               | CERT                 | IFIC      | ATE OF DEAT   | Н                      |                                      | Reg. Dist. No     | 103           | 21                      |
| 1. PLACE OF DEATH<br>o. COUNTY                            | BNITGOME  | RY                               | MAR                  | YLAND     | 2. USUAL RESIDENCE (A                                       | /here deceased         | d lived. If institution b. COUNTY    | n: Residence befo | ore odmiss    | ion)                    |
| b. CITY OR TOWN ( RURAT and give n                        | IN PINU   | s, write c.                      | BURS                 | ' IN 16   | c. CITY OR JOWN (IF   | outside corpo          | rote limits, write RU                | IRAL ond give ne  | arest town    | 1                       |
| d. NAME OF HOSPI<br>OR INSTITUTION                        | TAL (If not in haspital, g  | ve street addr                   | E AVE,               |           | d. STREET ADDRESS   | TIMOR                  | EAVE                                 |                   |               | IDENCE<br>FARM?<br>NO [ |
| 3. NAME OF<br>DECEASED<br>(Type or print)                 | OLI   | VE                               | Middle               |           | BADGER  | 4. DATE<br>OF<br>DEATH | SEPT.                                | 26                | ph.           | Yeor<br>19 <i>59</i>    |
| s. sex  | 6. COLOR OR RACE  | 7. MARRIED WIDOWED               | DIVORCE              |           | 8. DATE OF BIRTH // 0 V. 12, 1                              | 867                    | 9. AGE (In years lost birthdoy) yrs. | Months Doys       | Hours Hours   | R 24 MRS.<br>Min.       |
| On USUAL OCCUPATION OF WORK MEM 4                         | ON (Give kind of work or<br>rking life, even if retired)            | lone 10b. KINI                   | D OF BUSINESS (      | OR INDU   | DARLINGTE   |                        | ENNA.                                | 12. CITIZEN       | DF WHAT       | 4                       |
| 3. FATHER'S NAME  | LETCHMAN  |                                  |                      |           | 14. MOTHER'S MAIDEN   | NAME                   | RHOAD                                | ES                | 334           |                         |
| 1S. WAS DECEASED EVE<br>(Yes. no. or unknown)             | ER IN U. S. ARMED FORG  | rvice)                           | IAL SECURITY NO      | D. 17. 19 | NFORMANT<br>WARD & C.                                       | 4BLE,                  | 248 PAR                              |                   | AKON.<br>PARK | A Md.                   |
|   | ATH [Enter only one co<br>ATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) | - / /                            | or (0), (b), and (c) | The       | 10 cordin   | 0)                     | Asieles                              | ON                | ERVAL BE      | DEATH                   |
| Canditions, if a  | DUE TO  |                                  |                      | 2         |   | 9                      |                                      |                   | 7             |                         |
| gove rise to i<br>cause (o), stoting<br>lying couse lost. | the under-  |                                  |                      |           |   |                        |                                      |                   |               |                         |
| PART II. OT   |   |                                  | TRIBUTING TO DE      | ATH BUT   | NOT RELATED TO THE TERM                                     | MINAL DISEAS           | E CONDITION GIVE                     | N IN PART 1(0)    | PERFO         | AUTOPSY<br>RMED?        |
| 20a. ACCIDENT W. OR CONTRIBUTING                          | AS UNDERLYING DEATH MEDICAL EXAMINER)                               | 20b. DESCRIBI                    | E HOW INJURY O       | CCURRE    | D. (Enter nature of injury in                               | Port 1 or Port         | 111 of item 18.)                     | 3/8               | 8             |                         |
| 20c, TIME OF INJUI<br>Hour o. m.<br>p. m.                 | RY Month, Doy, Yeo  | r 20d. INJUR<br>While<br>at work | Not while at work    | 20e. PL   | ACE OF INJURY (Home, far<br>ctory, street, office bldg., et | m, 20f. (City          | or town)                             | (County)          |               | (Stole)                 |
| 21. I certify th  | hat I attended the  | deceased                         | fram                 | 27.       | , 19 <u>57</u> , ta   | 9/2                    | 6 , 1959                             | ,that I last s    | aw the        | decease                 |
| alive on  | 1/18  | _, 19_3 Z_                       | -,-, and that        | death     | occurred at   |                        | n the causes as                      |                   |               | ed abave                |
| ACTUAL<br>SIGNATURE                                       | 21144   | un da                            | 11.9                 |           | M.D. 113 CA   | rocke                  | ST NW                                | wash 12           | De:           | 1/26/50                 |
| PHYSICIAN'S NAME (Type)                                   | EAN H. HA.  | RDING                            | - ()                 |           | (OVER)  | **********             |                                      |                   |               |                         |
| 22a BURIAL CREMATIC                                       | SEPT. 29  | 1959 /                           | LT LING              | OLN       | R CREMATORY CEMETERY  | BiAU                   | TION (City, town, or                 | RJ. RG            | TUIN !        | Md.                     |
| 28 FUNERAL DIRECTOR                                       | IS SIGNATURE  | PARAL                            | ADDRESS ST ALMI.     | W151      | 4.12.DC DATE  | D BY REGIST            |                                      | TRAR'S SIGNATU    |               |                         |

III were last / foots, Er-wr. MANUFACTURE STREET, ST

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10342 CERTIFICATE OF DEATH director, filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY o. STATE filed b. COUNTY MARYLAND Monta omery funerol b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) pe RURAL and give nearest town) P Tark, d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS shing NAME OF Middle 4. DATE Last DECEASED (Type or print) DEATH Sen 002 Danes 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) WIDOWED M DIVORCED | yrs. ā COM 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) ff. US.Cout and 2++1 corbon 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicion certificote ном 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address ottending 11W 2 eose 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] a PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Rumon **DUE TO** þ Conditions, if ony, which gned gove rise to immediate DUE TO couse (o), stoting the underte hos been sig buriol-tronsit lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPS) emovo 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) While o. m. Not while of work of work 1959, that I last saw the deceased 21. I certify that I attended the deceased from and that death accurred at 7.750 M, from the causes and an the date stated above. alive an OR ADDRESS (Street, city or ACTUAL SIGNATURE O D moy be retoi PHYSICIAN'S James M. Whitlock NAME (Type) 220. BURIAL GOFMANION 226. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY abod Ft.Lincoln Cemetery Pr. Geo. Co., burial 23. FUNERAL DIRECTOR'S SIGNATURE Wash. D.C. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 9/5B

Montgomery

IF UNDER 1 YEAR IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

WARK

PERFORMED?

YES NO NO

(Stote)

DATE SIGNED

(Stote)

Days

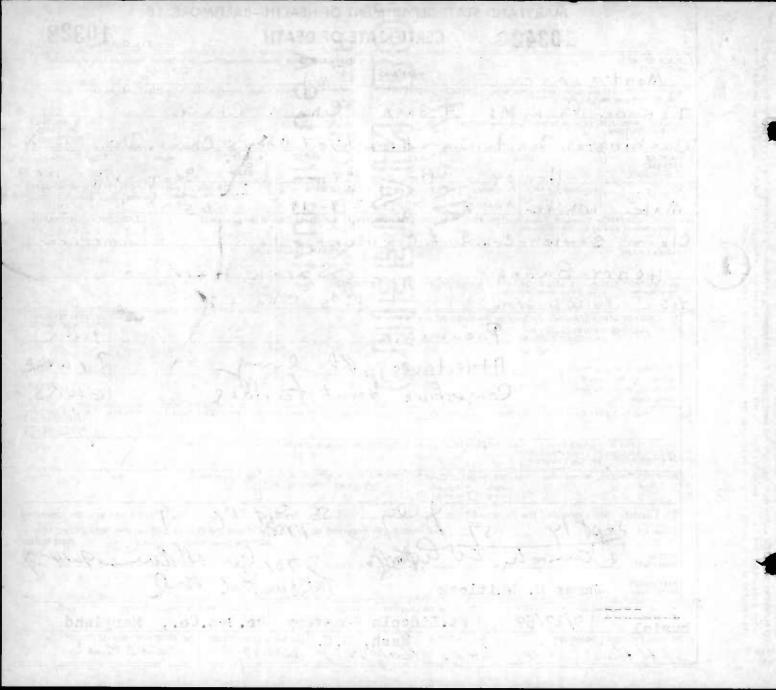
(County)

Months

ON A FARM? YES INO X

Year

19.5



10329

SEP 2 8 '59

Circhan S. Kraus

| PLACE OF DEATH O. COUNTY Montgome                              | ry                        | 1            |                       | MARYLAND      | 11          | NAL RESIDE                   |            |               |              |            | : Residenc | e befare a | dmission)                 |
|--|---------------------------|--------------|-----------------------|---------------|-------------|------------------------------|------------|---------------|--------------|------------|------------|------------|---------------------------|
| b. CITY OR TOWN (If RURAL and give ned                         |                           | s, write     | c. LENGTH             | OF STAY IN 16 | с.          | CITY OR TO                   | WN (If a   | utside carpo  | rate limits  | , write RU | RAL and g  | ve neares  | tawn)                     |
| Bethesda   |                           |              | 6 da                  | vs            | Wa          | shin                         | gton       | 1             |              | 4"         | 7x-3       | 3          |                           |
| d. NAME OF HOSPITA   | L (If not in hospital, gi | ve street o  |                       |               | d.          | STREET ADD                   | RESS       |               |              |            |            |            | S RESIDENCE               |
| U.S. Nav   | al Hospit                 | al,I         | Bethe:                | sda Md        | . 17        | 28 S                         | hepa       | rd S          | tree         | t          |            |            | ES NO                     |
| NAME OF<br>DECEASED  | Firs                      | i.           |                       | Middle        |             | Last                         |            | 4. DATE<br>OF |              | Manth      |            | Day        | Year                      |
| (Type or print)  | Robert                    |              | Har                   | rood          | BARF        | RETT                         |            | DEATH         | Sept         | embe       |            | 23         | 19 59                     |
| SEX  | 6. COLOR OR RACE          | 7. MARRI     | ED NEVEL              | R MARRIED     | B. DATE     | OF BIRTH                     |            | 11.4          | 9. AGE (     |            |            |            | OURS Min.                 |
| Male   | White                     | WIDOWE       |                       | DIVORCED      | J           | 1-20                         | -91        |               | 67           | yrs.       | Maining    | Duys II    | outs min.                 |
| during most of working   | N (Give kind of work d    | lane 10b.    | CIND OF BUS           | INESS OR INC  | USTRY 11    | . BIRTHPLAC                  | E (State o | ar foreign c  | ountry)      |            | 12. CITIZ  | EN OF WI   | HAT COUNTRY               |
| U.S. Army  |                           | U.           | S. G                  | overnm        | ent         | V                            | irgi       | nia           |              |            | U.         | S.         |                           |
| . FATHER'S NAME  |                           |              |                       |               | 14. A       | AOTHER'S M                   | AIDEN N    | AME           |              |            |            |            |                           |
| George B   | ARRETT                    |              | N 15                  |               |             | Dann                         | a Go       | dwin          |              |            |            |            |                           |
|  | IN U. S. ARMED FOR        |              | OCIAL SECU            | RITY NO.      | INFORM      | ANT                          |            |               |              | Addre      | SS         |            |                           |
| Yes  | 1913 -195                 |              | 3112                  | (             | Wife        | ) El                         | izah       | eth           | (n)          | Barr       | rett       | Same       | e as #                    |
| 1B. CAUSE OF DEAT  | TH [Enter only one car    | use per line | e for (a), (b),       | and (c).]     |             |                              |            |               |              |            |            | INTERV     | AL BETWEEN                |
|  | H WAS CAUSED BY:          | 1            | ne                    | morn          | il.         |                              |            |               |              |            | -          | 16         | AND DEATH                 |
| 1810   | DUE TO                    |              | ,                     | , ,           |             |                              | 0          | ٨             | 0 -          |            | ro Li      |            |                           |
| Conditions, if an  | v. which )                | m            | Lan                   | tile          | Car         | ours                         | ma         | 0             | Lla          | dder       |            | 10         | RA.                       |
| gave rise to im  | mediate (DUETO            |              | - /                   | 70            |             | 0                            |            | 1             |              |            |            | 0          |                           |
| lying cause last.  | he <u>under-</u>          |              |                       |               |             |                              |            | 0             |              |            |            |            |                           |
|  | ER SIGNIFICANT CONE       | DITIONS CO   | ONTRIBUTING           | G TO DEATH B  | JT NOT RE   | LATED TO T                   | HE TERMIN  | VAL DISEAS    | E CONDIT     | ION GIVE   | N IN PART  | F          | WAS AUTOPSY<br>PERFORMED? |
| 20a. ACCIDENT WAS<br>OR CONTRIBUTING (<br>(IF EITHER, NOTIFY A | CAUSE OF DEATH            | 20b. DESC    | RIBE HOW IN           | NJURY OCCUR   | RED. (Enter | nature of i                  | njury in P | art I or Par  | t II of iten | n 18.)     |            |            |                           |
| 20c. TIME OF INJURY<br>Havr a. m.<br>p. m.                     | Month, Day, Yea           | While        | JURY OCCUP<br>Nat whi | le            |             | INJURY (Ho<br>reet, office b |            |               | or town)     |            | (C         | ounty)     | (State                    |
| 21. I certify the  | at I attended the         | decease      | d fram                | 17 Sep        | t.          | 19 59                        | ta 23      | Sep           | t            | 19591      | hat I los  | t saw t    | he decease                |
|  | Sept.                     | 19           | 59 00                 | d that deo    | th occur    | rred at 4                    | : 00A      | 4 from        | the car      | ses and    | on the     | date st    | ated above                |
|  | 00 . 1                    | /            |                       |               | 0000        | 100 01                       |            |               |              |            |            |            | PATE SIGNE                |
| ACTUAL<br>SIGNATURE  | obert .                   | Br           | och                   | h             | MD [        | J.S.                         |            | al Ho         |              |            | -          | -          |                           |
|  |                           |              |                       | 1             |             |                              |            |               | P            |            |            |            |                           |
| PHYSICIAN'S NAME (Type) RC                                     | bert T.                   | BROO         | KS Jr                 | LT            | IG I        | I.S.                         | Nava       | 1 Ho          | spit         | al.E       | Bethe      | sda        | Md.                       |
| a. BURIAL, CREMATION   | , 22b. DATE THEREO        | F            | 22c. NAME             | OF CEMETERY   | OR CREM     |                              |            | 22d. LOCA     | _            | -          |            |            | (State)                   |
| Burial (Specify)   | 9/-25-5                   | 9            | Arl                   | ington        | Nat         | ciona                        | 1          | Ar            | ling         | ston       | Virg       | gini       | a                         |
| FUNERAL DIRECTOR'S   | 1 - 0-                    |              | ADDRES                | -             |             |                              |            | BY REGIST     |              | 4b. REGIST | RAR'S SIG  | NATURE     |                           |
| R A Pump   | mey 75                    | 57 W.        | scon                  | sin Av        | P. F        | Retha                        | Selve      | Mck.'5!       | 9            | Citt       | 9 4        | -          |                           |

| Sena dana      | TOWNSON - THE SHOP HOW                  | MICHAEL STATES | STRUMENT STRUMENT     |
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|                | . 1730 Shoperd Syrae                    | Becheaga Mo    | O.E. Mayol Hospinal,  |
| mber 23        | Magazin Line Transas                    | booksall       | Product Rubers        |
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|                | Danna Godwin                            |                | Coorge ENGINET.       |
| nerett Juma en | (a) stockwill (all)                     |                | Mei- Fiel - A         |
|                |   | Some of        |                       |
| *              |   |                |                       |
| Magelles 10    | ACC. ACC. ACC. ACC. ACC. ACC. ACC. ACC. |                | . HB 35               |
|                | M. T.S. Navač Nespik                    |                |                       |
| almigniv ma    | Meridosi Arilog                         | otar In        | 196-38-9 17 5 6 4 C 5 |
|                | ve. Sethenda Mi.                        | A minimore.    | hall events the room  |

VS A1S (4) 1SM 10/S7

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CEPTIFICATE OF DEATH

| 1 0               |   |   | OEK III TO  | AIL OI BLAII   |  | Reg. Dist. No.       |                                       |
|-------------------|---|---|---|--|--|----------------------|---------------------------------------|
| 0.                | LACE OF DEATH<br>COUNTY<br>Montgomer                                      |   | MARYLAND  | 2. USUAL RESIDENCE (Who o. STATE North Caro  | ere deceased lived. If institu<br>b. COUNT       |                      | admission)                            |
| Ь                 | RURAL ond give nea  | outside corporate limits, writerest town)                             |   |  | utside corporate limits, write                   | RURAL and give neare | est town)                             |
|                   | Bethesda  |   | 91 days   | Asheville  | 70   | X - 3                |                                       |
| d                 | or institution The Clini  | L (If not in hospitol, give str. cal Center, Be                       | ethesda lli, Md.  | d. STREET ADDRESS  110 Annand  | ale Avenue                                       |                      | IS RESIDENCE<br>ON A FARM?<br>YES NO  |
| D                 | IAME OF<br>DECEASED<br>Type or print)                                     | First<br>David  | Middle<br><b>Lee</b>  | Bartlett   | 4. DATE MOF SEPTE                                | onth Day             | Yeor<br>1959                          |
|                   | Male  | White wind  | OWED DIVORCED   | B. DATE OF BIRTH  January 14, 1  |  | Months Days          | Hours Min.                            |
| 00.<br>3 <b>e</b> | usual Occupation during most of working rvice Stat                        | N (Give kind of work done Ing life, even if retired)                  | t Private   | STRY 11. BIRTHPLACE (Stote of North C  |  | 12. CITIZEN OF       | WHAT COUNTI                           |
| 3. F              | FATHER'S NAME   | E. Bartlett   |   | 14. MOTHER'S MAIDEN N  | Spears   |                      |                                       |
| IS. V<br>(Yes.    | WAS DECEASED EVER   | IN U. S. ARMED FORCES? yes, give wor or date of service) None         |   | NFORMANT THE Medical Centre Clinical Centre Chinical Chinical Centre Chinical Chi | cal Record Ad                                    |                      | land                                  |
|                   | PART I. DEATI   | H [Enter only one couse per<br>H WAS CAUSED BY:<br>MMEDIATE CAUSE (o) | er line for (o), (b), ond (c).] Intracranial and            | subarachnoid   | hemorrhage                                       | INTER                | VAL BETWEEN<br>I AND DEATH<br>6 hours |
|                   | Conditions, if ongove rise to im couse (o), stoting the lying couse lost. | which (b)   | Acute leukemia  |  |  |                      | 9 month                               |
| CATION            | PART II. OTHE   | epticemia   | NS <u>CONTRIBUTING TO DEATH</u> BUT                         | NOT RELATED TO THE TERMIN  | NAL DISEASE CONDITION G                          |                      | WAS AUTOPSY<br>PERFORMED?<br>YES NO   |
| CERTIF            | 20a. ACCIDENT WAS<br>OR CONTRIBUTING [<br>(IF EITHER, NOTIFY W            | UNDERLYING [] 20b. ( CAUSE OF DEATH (EDICAL EXAMINER)                 | DESCRIBE HOW INJURY OCCURRE                                 | D. (Enter noture of injury in Po   | ort I or Port II of item 1B.)                    |                      |                                       |
| MEDICAL           | 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.                                | WI  | d. INJURY OCCURRED 20e. PL. hile Not while for work of work | ACE OF INJURY (Home, farm, ctory, street, office bldg., etc.)  | 20f. (City or town)                              | (County)             | (Stote                                |
|                   | alive an Sept   |   | eased from June 3, 959, and that death                      | accurred at 2:30 1   | M, fram the causes  DORESS (Street, city or town | and an the date      | the decea<br>stated abo<br>DATE SIGN  |
|                   | ACTUAL  | 18112501120 11  | Daydow m.D.   | me The Clinica   | al Center  |                      | 9-2-59                                |
|                   | ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)  L                              | awrence A. Ga   | aydes, M. D.  | The Nation   | al Institutes                                    | of Health            | 1                                     |

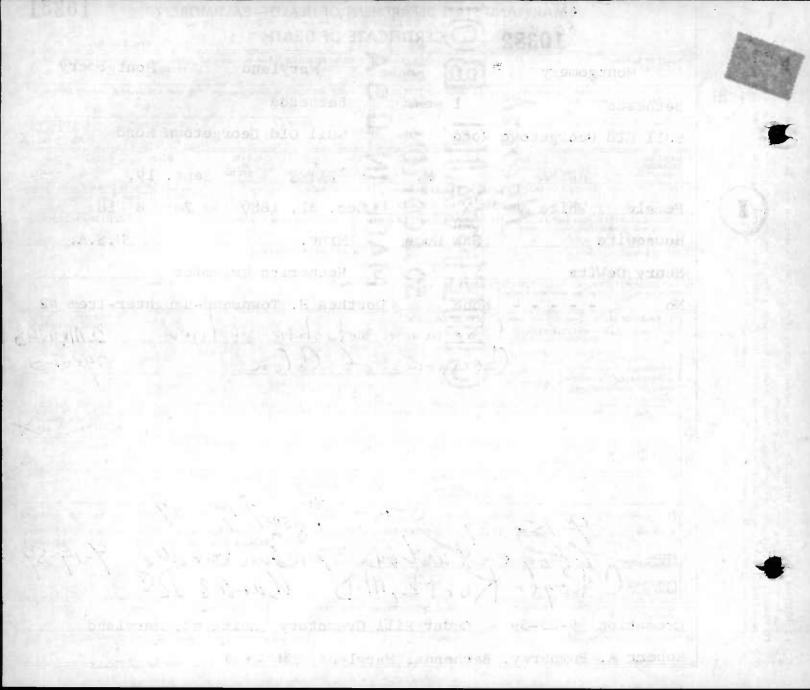
|           |  | WARE TO THEM!  | PARE DEPAR    |  |   |
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|           | anager J   | PART OF HAD  | 1000          | F05.014  |   |
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| ew        | mother is  | ound to may the  |               |  |   |
|           |  |  |               | TEND OF PARETY   |   |
|           | hemigrade, d   | Labsonieli<br>mww.exh  |               | THE STATE OF THE S |   |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10389 CERTIFICATE OF DEATH

| 70002   |                        | 0   |   | Reg. Dist. No.  |
|---|------------------------|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery  | MARYLAND               | 2. USUAL RESIDENCE (Who a. STATE Mary)                      | ere deceased lived. If institution and b. COUNTY  | Montgomery  |
| b. CITY OR TOWN (If autside corporate limits, write c. RURAL and give nearest town)                                 | LENGTH OF STAY IN 16   | c. CITY OR TOWN (IF o                                       | utside corporate limits, write F                  | RURAL and give nearest town)                          |
| d. NAME OF HOSPITAL (If not in hospitol, give street addr<br>90111 old Georgetown Ros                               | ad                     | / d. STREET ADDRESS<br>/ 9011 01d                           | Georgetown  | Road e. IS RESIDENCE ON A FARM? YES NO NO             |
| 3. NAME OF DECEASED (Type or print) ADENA   | Middle M .             | Lost<br>BATES   | 4. DATE Mor                                       | 19, Day Year<br>19, 1959                              |
| S. SEX    6. COLOR OR RACE   7. MARRIED   | DIVORCED 🗍             | Dec. 31. 1  | 9. AGE (In years lost birthday)<br>880 80 78 yrs. | Months Days Hours Min                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife              | MF BUSINESS OR INDU    | STRY 11. BIRTHPLACÉ (State                                  | or foreign country)                               | 12. CITIZEN OF WHAT COUNTRY?                          |
| 13. FATHER'S NAME   |                        | 14. MOTHER'S MAIDEN N                                       | IAME  |   |
| Henry DeWitz  | 100                    | Hennerit  | a Krigmier  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC (Yes, no, or unknown)   (If yes, give war or dates of service) | IAL SECURITY NO.       | NFORMANT  |   | Iress   |
| No Nor  | ne De                  | orthea H. To  | ownsend-daus                                      | hter-Item #2  |
| 1B. CAUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)              | r (a), (b), and (c).]  | metastatie  | of liver  | INTERVAL BETWEEN ONSET AND DEATH                      |
| 153.8 DUE TO  |                        | 170   |   | 0.4   |
| Canditians, if ony, which ) (b)   | curous                 | ort Colo  | n   | 19624-5   |
| gave rise to immediate DUE TO   |                        |   |   |   |
| lying cause last. (c)   |                        |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CON   | TRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMI                                    | NAL DISEASE CONDITION GI                          | VEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO NO |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | E HOW INJURY OCCURRE   | D. (Enter nature of injury in I                             | Part I or Part II of item 18.)                    |   |
| Oc. TIME OF INJURY Month, Doy, Year 20d. INJURY Hour a. m. While p. m. 19 at work                                   | Not while fo           | ACE OF INJURY (Hame, farm ctary, street, affice bldg., etc. | , 20f. (City or tawn)                             | (Caunty) (State)                                      |
| 21. I certify that Lattended the deceosed   | from 8-20              | - 1957, to  | 9-19-159  | that I last sow the deceosed                          |
| alive on 4- 15-5, 1939  | and that death         | occurred at \$ 5  | M, from the couses or                             | nd on the date stoted obove                           |
|   | 1 of for               |   | ADDRESS (Street, city or town,                    | state) DATE SIGNED                                    |
| ACTUAL SIGNATURE OF CONT  | x word by              | ND. 2/0/67  | un Ous M  | 0 1-14-59   |
| PHYSICIAN'S COPER   | with, 11               | 1.B 11  | liste 8.D   |   |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22 REMOVAL (Specify)  | c. NAME OF CEMETERY O  | R CREMATORY   | 22d. LOCATION (City, town,                        | ar county) (State)                                    |
| Cremation 9-23-59 (   | Cedar Hill             | Crematory   |   | Maryland  |
| 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                | 24a. REC'I  | D BY REGISTRAR 24b. REG                           | ISTRAR'S SIGNATURE                                    |
| Robert A. Pumphrey, Bet   | hesda, Ma              | ryland DATSEP   | 24'59 an  | 1-9-16  |
|   |                        |   |   |   |

rely filled in by the funeral director, TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs may be retail by the hospital ar attending physician.

TO FUNERAL B. CTOR: After this certificate has been signed by the attending physician and constructly filled in binage 3 shauld be detached for use as the burial-transit permit. Then please remaye carban apers. Ages 1 and the registrar priar to burial, cremation, ar remayal, and in any event within 72 haurs after detth. VS A15 (4) 1SM 9/SB



TO HOSPITAL OR

VS A15 (4) 15M 9/55

after death. Page 4

| ARYLAND | STATE | DEPARTMENT | OF HEA | LTH—B | ALTIMORE, | 18 |
|---------|-------|------------|--------|-------|-----------|----|
|         |       |            |        |       |           |    |

10383

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 10332

|   |  |            |                            |           |                |   |              |                                 | Wall b      | 131. 110.                             |         |            |
|---|--|------------|----------------------------|-----------|----------------|---|--------------|---------------------------------|-------------|---------------------------------------|---------|------------|
| 1. PLACE OF DEATH   | ntgomerv                                       |            | MARYLANI                   |           | o. STATE       | DENCE (Wh                               |              | d lived. If institution b. COUN | Y VI        | nce before                            |         |            |
|   | outside corporate limit                        | s, write   | c. LENGTH OF STAY IN 1     | b .       |                |   |              | orote limits, write             |             |                                       |         |            |
| RURAL and give ned  | arest town)                                    |            |                            | V         |                |   |              |                                 |             |                                       |         | •          |
|   | ngsville                                       |            | 1                          | 1         |                |   | - Let        | visdale                         | 1           |                                       |         |            |
| OR INSTITUTION  | AL (If not in hospital, g                      | ive street | oddress)                   | 1         | d. STREET A    |   |              |                                 |             |                                       | IS RESI |            |
| R.F.D.  | Monrovia                                       |            |                            |           | R              | .F.D                                    | . Cla        | arksbur                         | g           |                                       | YES [   | NO         |
| 3. NAME OF  | Fire   | st         | Middle                     |           | Los            | t                                       | 4. DATE      | M                               | onth        | Day                                   | ,       | feor       |
| (Type or print)   | Barr   | v          | R. B                       | eal:      | 1              |   | OF<br>DEATH  | Sent                            | . 10        |                                       | 1       | 1959       |
| 5. SEX  |  |            | RIED NEVER MARRIED         |           | TE OF BIRTI    | н                                       |              | P. AGE (In year                 | IF UNDE     | RIYEAR                                |         |            |
|   |  | WIDOWI     |                            |           |                |   | 06           | lost birthdoy                   | Months      | Days                                  | Hours   | Min.       |
| Male  | White  |            | - 65                       |           | ec. 1          |   |              | 72 y                            |             |                                       |         |            |
| during most of worki  | ing life, even if retired                      | done 10b.  | KIND OF BUSINESS OR IN     | DUSTRY    | II. BIRTHPL    | ACE (Stote                              | or foreign o | country)                        | 12, C       | IIIZEN OI                             | WHAI    | COUNTRY    |
| Dairy Fa  | armer  |            | Own farm                   |           | Lew            | isda                                    | le. I        | ٧d.                             |             | USA                                   |         |            |
| 13. FATHER'S NAME   |  |            |                            | 14        | . MOTHER'S     | MAIDEN N                                | NAME         |                                 |             |                                       |         |            |
| Richard   | Cronin   | Real       | 1                          |           | Sal            | Tw Ta                                   | awson        | 2                               |             |                                       |         |            |
|   |  |            | SOCIAL SECURITY NO. 17     | . INFOR   |                |   | 241201       |                                 | ddress      |                                       |         |            |
| (Yes, no or unknown)  | If yes, give war or dates of se                | ervice     |                            |           |                |   | ToT          | Deall                           | 070         | al-ah                                 |         | Ma         |
| No  |  |            | 5-36-7380                  | TAT       | 188 E          | stne                                    | L. M.        | Beall,                          | O La        |                                       |         |            |
|   |  | use per li | ne for (o), (b), and (c).] |           |                |   |              |                                 |             |                                       | RVAL BE |            |
| A .   | TH WAS CAUSED BY: IMMEDIATE CAUSE (o           | Ac         | ute Coronai                | CY C      | cclu           | sion                                    |              |                                 |             | 1                                     | mir     | nute       |
| 420.1   | DUE TO   |            |                            |           |                |   |              |                                 |             |                                       |         |            |
| Conditions, if on   | iy, which ) (b                                 | Ca         | rdio-vascu                 | lar-      | -rena          | l dis                                   | sease        |                                 |             | 1                                     |         |            |
| gove rise to in   | nmediate (                                     |            | neralized a                |           |                |   |              |                                 |             | 15                                    | yes     | ers        |
| lying couse lost.   | he under-                                      |            | revious art                |           |                |   |              | s reti                          | nel         | -                                     | 3       |            |
|   | ) (c   |            | FORTRIBUTION TO BEACH      |           |                |   |              |                                 |             | DT 1/-1 10                            | MAG     | ALITOPSY   |
| PART II. OTH  | EK SIGNIFICANT CON                             | DITION     | SOLAH MEMBER MANAGEMENT    | UI MOI    | KELATED IC     | ) THE TERMI                             | INAL DISEA:  | SE CONDITION (                  | DIVEN IN PA | KI 1(0) 17                            | PERFO   | RMED?      |
| 5   |  |            |                            |           |                |   |              |                                 | Fr. L       |                                       | YES []  | NO 2       |
| PART II. OTH  200. ACCIDENT WAN OR CONTRIBUTING (IF EITHER, NOTIFY) | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER) |            | CRIBE HOW INJURY OCCUI     | RRED. (Er | nter noture o  | f injury in f                           | Port I or Po | rt II of item 18.)              |             |                                       |         |            |
|   | MEDICAL EXAMINER)                              | N          | o injury.                  |           |                |   |              |                                 |             |                                       |         |            |
| 20c. TIME OF INJURY<br>Hour o. m.                                   | Month. Day, Yes                                | or 20d. II | NJURY OCCURRED 20e.        |           | OF INJURY (    |   |              | y or town)                      |             | (County)                              | -,      | (Stote)    |
| Hour o.m.   | 19   | While      | Not while                  | toctory,  | street, office | e bldg., etc.                           | .)           |                                 |             |                                       |         |            |
|   | ***************************************        |            | 7                          |           | 35             | 0,                                      | ant          | 10 6                            | 0           |                                       |         |            |
| 21, 1 certify the   | at I attended the                              | deceas     | ed from Jan.               |           | , 1900         | , ta De                                 | ept.         | 10, 195                         | ,that I     | last sa                               | w the   | deceased   |
| alive on Sep  | t. 9, 19                                       | 919        | , and that dec             | ath acc   | curred at      | 9:T                                     | M, fra       | m the causes                    | and an      | the date                              | e state | d abave    |
| 7   | 70.  |            | a                          |           |                | IF C.                                   | ADDRESS (S   | itreet, city or tow             | n, stole)   |                                       | D/      | ATE SIGNED |
| ACTUAL<br>SIGNATURE   | - 4 Rem  | Dre        | · Doza                     | M.D.      |                |   |              |                                 |             |                                       | 9/1:    | 1/59       |
| M   | McKendre                                       | e Bo       | ver. D                     |           | Drui           | d The                                   | aatre        | Build                           | ing.        |                                       |         |            |
| PHYSICIAN'S NAME (Type)   | 11101101101                                    |            | 30-1                       |           |                |   |              | ryland                          | 0-          |                                       |         |            |
| 220. BURIAL, CREMATION  | 1 205 DATE THEREO                              | \E         | 22c. NAME OF CEMETER       |           |                | LLUB.                                   |              | TION (City, town                |             |                                       |         |            |
| Burial (Specify)  | O /3 7 /-                                      | / -        |                            |           |                |   | -            |                                 | ,           |                                       | (Stote  | ej         |
|   | 19/13/59                                       |            | Bethesda                   | Me        | thodi          |   |              | Brownir                         | gsvi        | lle,                                  | Md      | •          |
| 23. FUMERAY DIRECTORS   | SIGNATURE                                      | 4          | ADDRESS                    | 3.5       |                | 240. REC'                               | D BY REGIS   | IRAR 24b. RE                    | GISTRAR'S S | GNATUR                                | A       |            |
| Cum of  | · provest                                      | mu         | ~ Damascus                 | , MC      | 1.             | DATE DE                                 | "L 12"       |                                 | 7,1         | · · · · · · · · · · · · · · · · · · · |         |            |
|   |  |            |                            |           |                | *************************************** |              |                                 |             |                                       |         |            |

BRSI, Of . cet 4 Because Marie Comment of the AND A Private lawers Line Langue College in

| OF HEALTH—BALTIMORE, | 18                   |
|----------------------|----------------------|
|                      | OF HEALTH—BALTIMORE, |

10343 CERTIFICATE OF DEATH

|   |   |  |   | Reg. D                                | Dist. No.                                       |     |
|---|---|--|---|---------------------------------------|---|-----|
|   | 1. PLACE OF DEATH G. COUNTY MENTAGMERY MA   | RYLAND 2. USUAL RESI                               | CENCE (Where deceased liver<br>Karyland | d. If institution: Reside             | ence before admission)                          |     |
|   | b. CITY OR TOWN (If sociate corporate limits, write RURAL and give negrest town)  All Market Corporate limits, write c. LENGTH OF STA   |  | OWN outside corporate I                 | Jank RURAL ond                        |   |     |
|   | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR WAY AVENUE  | d. STREET A  | Davis Qu                                | enul                                  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO         |     |
|   | 3. NAME OF DECEASED (Type or print)  3. NAME OF DECEASED (Type or print)  3. NAME OF BARN   | ES BEA   | 30                                      | 5ept                                  | Doy Year<br>5 19 5                              | 9   |
|   | 5. SEX 6. COLOS OR RACE 7. MARRIED PREVER MAR WIDOWED DIVOR   | RRIED   8. DATE OF BIRTI                           | 1893                                    | GE (In years st birthday) Manths yrs. | R 1 YEAR IF UNDER 24 HRS Doys Hours Min.        | 5.  |
| 1 | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS Buring most of working life, every if retired)  Automore  | or INDUSTRY 11. BIRTHPL                            | ACE (Stole or foreign country           | md. 12. C                             | ITIZEN OF WHAT COUNTY                           | RYS |
|   | 13. FATHER'S NAME Beam  | 14. MOTHER'S                                       | MAIDEN NAME Z                           | S.                                    |   |     |
|   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY N (Yes, ng. o, unknown) (If yes, give wer or dates of service) 214-03-92   | 17. INFORMANT<br>08 Mrs. Lue                       | y P. Bea.                               | M, CDA                                | eme as #2)                                      |     |
|   | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and ( PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancin or  | ~ /-   | iver mil                                | astasis                               | INTERVAL BETWEEN ONSET AND DEATH                | = 2 |
|   | 156.) Conditions, if ony, which ) (b)   |  |   |                                       |   |     |
|   | gove rise to immediate cause (a), stating the <u>under-lying couse lost.</u>   DUE TO   Column   Column |  |   |                                       |   |     |
| 0 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D   | DEATH BUT NOT RELATED TO                           | THE TERMINAL DISEASE CON                | NDITION GIVEN IN PA                   | RT 1(0) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |     |
|   | 206. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | OCCURRED. (Enter noture o                          | injury in Port 1 or Port II of          | item 18.)                             | 2.000   |     |
|   | 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED While Not while of work of wark   | 20e. PLACE OF INJURY (I<br>foctory, street, office | tome, form, bldg., etc.)                | wn)                                   | (County) (State                                 | )   |
|   | 21. I certify that lattended the deceased from Ale  | at death accurred at                               | to 5 Sopt                               |                                       | last saw the deceas                             |     |
|   | ACTUAL SIGNATURE SIGNATURE  | 40 7//   |   | city or town, state)                  | DATE SIGN                                       |     |
|   | PHYSICIAN'S M. B QUEEN  | Tako   | ma Pock,                                | Md                                    | 195   | è   |
|   | 220. BURIAL, CREMATION, 226-DATE THEREOF 222. NAME OF CE  | METERY OR CREMATORY                                | 22d JOCATION<br>Prince                  | (Cipy Jown, or county)                | custy (Store) Md                                | 4   |
|   | FUNERAL DIRECTOR'S SIGNATURE 254 CARROLL  | Mrw DE   | 240. REC'D BY REGISTRAR DATE SEP 9 '59  | 24b. REDISTRAR'S SI<br>Carthur        | 2 Kraus   |     |

MARYLAND SERIES SERVICE OF HEALTH-MARK SHELLYSAM HTARE SO STADISHED ING. 2 ME.

VS A15 (4) 15M 9/5B

| MARYLAND | STATE | DEPARTMEN | NT OF | HEALTH- | -BALTIMORE, |
|----------|-------|-----------|-------|---------|-------------|
| 4000     | 20.2  |           |       |         |             |

10384 CERTIFICATE OF DEATH

Reg. Dist. No. 10334

| 1. PLACE OF DEATH 0. COUNTY Montgomery MARYLAND   | o. STATE Maryland  b. COUNTY Montgomery   |
|---|---|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Bethesda  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  **Bethesda**                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION 4702 Highland Ave.   | d. STREET ADDRESS  4702 Highland Ave.  6. IS RESIDENCE ON A FARM? YES □ NO ■  |
| 3. NAME OF First Middle (Type or print) RUFUS C. BE   | EAVERS  4. DATE OF DEATH Sept. 26 Year 1959   |
| Male White WIDOWED DIVORCED   | B. DATE OF BIRTH  Jan. 26, 1887  9. AGE (In yeors lost bithdoy) 72 yrs.  IF UNDER 1 YEAR IF UNDER 24 HRS.  Months Days Hours Min. |
| Occupation (Give kind of work done during most of working life, even if retired)  Retired-  Retired-  Retired-  | Virginia U.S.   |
| John Thomas Beavers   | 14. MOTHER'S MAIDEN NAME Ann ?  |
| (Yes, no, or unknown) (If yes, give war or dates of service)  | race E. Beavers  Address Same as Item #2.   |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO                                     | Interval Between ONSET AND DEATH  |
| Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.  DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?                                       |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | PES NO. (Enter noture of injury in Port I or Port II of item 18.)   |
|   | ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) ctory, street, office bldg., etc.)                                |
| 21. I certify that I attended the deceased fram alive an 25, 1959, and that death   | accurred at 12 13M, from the causes and an the date stated abave.  ADDRESS (Street, city or town, stole)  BO16 Old Georgetown Rd. |
| PHYSICIAN'S LEO I. DONOVAN  | Bethesda, Md. 9-26-59   |
| 220. BURIAL, CREMATION, PERMOVAL (Specify) 9-29-59 Congression  | al Cemetery Washington, D. C.   |
| 23. FUNERAL BIRECTOR'S TO THE THE BETHESDA, Mar   | yland 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 2 9 '59 Colons & Krains   |

HIME SO STAURINGS CLASSICS Yue and out of a family man a second to the suppose and the su and the complete sea gate howing the Surv wales will be and the sale of No. on the contract of the con The second of th The State of the S

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| ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, | 18            |
|---|---------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH       | Reg. Dist. No |

M

10335

|  |   | -           |                                 |                    |                                       |                     |                        |  |          |        |           |         |
|--|---|-------------|---------------------------------|--------------------|---------------------------------------|---------------------|------------------------|--|----------|--------|-----------|---------|
| 1. PLACE OF DEATH<br>a. COUNTY                               | Montgome  |             | MARY                            |                    | o. STATE                              | Mas                 |                        | lived. If Institu  | Y        |        |           | ission) |
| b. CITY OR TOWN  | Ilf outside corporate limits, write                 |             | c. LENGTH OF STAY               | IN 1b              | c. CITY OR TO                         | WN (If              | autside carpor         | ate limits, write  |          | ampo   |           | wn)     |
| end give neorgest to   | esda  |             | 8 hrs                           | 3                  | Wes                                   | tfi                 | leld                   | 5  | 8x.      | 3      |           |         |
|  | PITAL OR INSTITUTION (                              |             |                                 | s)                 | d. STREET ADD                         |                     |                        |  |          |        |           | A FARM? |
| (Traile  | r truck) I  | lamae       | n Lane                          |                    |                                       | Pal                 | Lmer A                 | ve.  |          |        | YES [     | LON [   |
| 3. NAME OF<br>-DECEASED<br>(Type or print)                   | Honar   |             | Middle<br>J                     | Ве                 | gin                                   |                     | 4. DATE<br>OF<br>DEATH | Sep  |          | Day    |           | 19 59   |
| 5. SEX   |   | 7. MARRIE   | D NEVER MARRIED                 | 8. D.              |                                       |                     | -                      | AGE (In years<br>last highlay)   |          | _      |           | Min.    |
| Male   | White   | WIDOWED     | DIVORCED                        |                    | April                                 | 24                  | 1898                   | 6.1 yrs.   | Mogths   | OTO    | Hours     | 100     |
| during most of work  Retir                                   | TION (Give kind of work king life, even if retired) | pa          | ind of Business or per-maker    | INDUSTRY           | 11. BIRTHPLACE                        | (Slote              | or foreign coun        | itry)  | 12. CI   |        | E WHAT    | COUNTRY |
| 13. FATHER'S NAME  |   |             |                                 | 1.                 | . MOTHER'S MAI                        | DEN N               | NAME                   |  | -173     |        |           |         |
| Unk  | nown  |             |                                 |                    |                                       | Ur                  | ıknown                 |  |          |        |           |         |
| 15. WAS DECEASED I   | EVER IN U. S. ARMED FO                              | RCES? 16.   | SOCIAL SECURITY NO.             | 17. INFC           | PRMANT                                |                     |                        | Address  |          |        |           |         |
| No   |   | У           | es-unknow                       | n A                | lvah B                                | uck                 | more sc                | n-in-  | Law      |        |           |         |
| Canditions, if gove rise to imm (o), stoling the couse tast. | nediote couse                                       |             | nonary                          |                    | PELATED TO THE                        |                     | INAL DISEASE C         | ONDITION GIV   | FN IN PA | 100    | ET AND DE | Herry   |
| ST S                     |   |             |                                 |                    |                                       | LAN                 | THE DIGETOR OF         |  |          |        | PERFC     | NO Z    |
| PART II. O   | AUSE WAS ONTRIBUTING []                             | b. DESCRIBE | HOW INJURY OCCUR                | RED. (Enle         | r nature of Injury                    | in Parl             | t I ar Part 11 of      | ilem 18.)  |          |        |           |         |
| 20c. TIME OF IND   | n.  | While       |                                 | 0e. PLACE factory. | OF INJURY (Home<br>street, affice bld | e, farm<br>g., etc. | 20f. (City or          | town)  | (C       | aunty) |           | (Stote) |
| death resulte  ACTUAL SIGNATURE  EXAMINER'S NAME (Type)      | that I took charge and from: Natural Breach J.      | Bar Biro    | J. Accident □,  oschart  sch2,7 | , Suicio           | A.D. CHIEF MEDI                       | CAL EX              | AL EXAMINER EXAMINER   | 9  | cause [  | _ 53   | DATE S    | SIGNED  |
| Bur-Tran   | S1t 9/4/59  |             | St. Mary                        |                    |                                       |                     |                        | ield,  | Mas      | s.     | (Stat     | le)     |
| 23. FUNERAL DIRECTO  |   |             | ADDRESS                         | 2.6                |                                       |                     | D BY REGISTRA          | A STATE OF THE PARTY OF THE PAR |          |        |           |         |
| Robert   | A. Pumphre  | ey B        | ethesda,                        | Mary               | Land                                  | SEF                 | 8 '59                  | anti   | hun &    | France | 0         |         |

VS. A15ME(5) 5M 9/55

| and the             |  |                       |   |       |
|---------------------|--|-----------------------|---|-------|
|                     |  |                       | Tables in postery                               |       |
|                     |  |                       |   |       |
|                     |  | and Property          |   |       |
|                     | (H2 )  |                       |   |       |
|                     | NIGHT AS MESSA.  |                       |   | a Cal |
|                     | •  | 19/88-101             |   |       |
|                     | Spiles and   |                       |   |       |
| Walled Cour         |  | anii anii anii anii a |   |       |
|                     |  |                       |   |       |
|                     |  |                       | Grine (   |       |
|                     |  |                       |   |       |
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|                     |  |                       |   |       |
|                     | un di distanti di ini di<br>1713 I ministrati i i di   | Don't B               |   |       |
|                     | Spinish to the time of the same of the sam |                       | N. P. D. S. |       |
| Lego, house         |  |                       |   |       |
| mytalini marinda ay |  |                       |   |       |

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

TO HOSPITAL OR TO FUNERAL D

VS A15 (4) 15M 10/57

page 3 shauld of detached for use as the burial-transit permit. Then please remove carbon the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after de

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### EATH

10336

| 10386         |  | CERTIFICATE OF D |                 |  |  |
|---------------|--|------------------|-----------------|--|--|
| LACE OF DEATH |  | MARYLAND         | 2. USUAL RESIDI |  |  |

Rea Dist No

|                                      |  |                               |                                   | vaa.  | DI31. 140.                    |  |  |
|--------------------------------------|--|-------------------------------|-----------------------------------|---|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgome | 2007   | MARYLAND                      | O. SIAIE                          | here deceased lived. If institution: Reside   | 1/                            |  |  |
|                                      | (If outside corporate limits, wr                                   | ite c. LENGTH OF STAY IN 16   | Maryland                          | Montgomer  outside corporate limits, write RURAL and  |                               |  |  |
| RURAL ond give                       | neorest town)  |                               |                                   | ouside corporate limits, write RORAL and  | 3 give nearest town)          |  |  |
| Bethesda                             |  | 11 days                       | X Bethesda                        |   |                               |  |  |
| OR INSTITUTION                       | PITAL (If not in hospital, give st<br>N                            | reel oddress)                 | d. STREET ADDRESS                 |   | e. IS RESIDENCE<br>ON A FARM? |  |  |
| The Cli                              | nical Center.  | Bethesda 14. Md.              | 5209 Chand                        | ler Street  | YES NO NO                     |  |  |
| 3. NAME OF<br>DECEASED               | First  | Middle                        | Lost                              | 4. DATE Month   | Day Year                      |  |  |
| (Type or print)                      | Delbert  | Mauritz                       | Bergenstal                        | OF DEATH September  |                               |  |  |
| S. SEX                               | 6. COLOR OR RACE 7.  | MARRIED NEVER MARRIED         | B. DATE OF BIRTH                  |   | ER 1 YEAR IF UNDER 24 HRS.    |  |  |
| Ma7 -                                |  | OWED DIVORCED                 | D                                 | lost birthdoy) Months   |                               |  |  |
| Male                                 | El Adams V C   | 10b. KIND OF BUSINESS OR INDU | December 23,                      | 1917   11 yrs.  |                               |  |  |
| during most of w                     | orking life, even if refired)                                      |                               |                                   |   | CITIZEN OF WHAT COUNTRY       |  |  |
| Physicia                             | ın   | Government                    | Miss                              |   | U.S.A.                        |  |  |
| 13. FATHER'S NAME                    |  |                               | 14. MOTHER'S MAIDEN N             | AME   |                               |  |  |
| Carl Ber                             | genstal  |                               | Stena Jens                        | en  |                               |  |  |
|                                      | VER IN U. S. ARMED FORCES?  (If yes, give wor or dates of service) | 16. SOCIAL SECURITY NO. 17.   |                                   | dical Record Address  |                               |  |  |
| No                                   | (if yes, give war or agres or service)                             | Improilable T                 |                                   | enter, Bethesda 14  | Manual and                    |  |  |
|                                      | EATH [Enter only one couse p                                       | er lies for (s) (b) and (s) ? | ne orrurgal of                    | Buter, betnesda III   |                               |  |  |
|                                      |  |                               | - 15173                           |   | ONSET AND DEATH               |  |  |
|                                      | MAS CAUSED BY: M   | yocarditis due t              | о нурекатепта                     |   | 24 hours                      |  |  |
| 580 X                                |  |                               |                                   |   |                               |  |  |
| Conditions, if                       |  | ost Necrotic Cir              | rhosis                            |   | 2½ Years                      |  |  |
| gove rise to                         |  |                               |                                   |   |                               |  |  |
| lying couse los                      | i. U   | remia                         |                                   |   | 2 days                        |  |  |
| PART II. O                           |  |                               | NOT RELATED TO THE TERMI          | NAL DISEASE CONDITION GIVEN IN PA   |                               |  |  |
| 5 Staphy                             | ylococcal Pyel   |                               |                                   | The District College of the College | PERFORMED? YES NO             |  |  |
| 200. ACCIDENT V                      | VAS UNDERLYING [ 20b. IG [ CAUSE OF DEATH Y MEDICAL EXAMINER)      | DESCRIBE HOW INJURY OCCURRE   | D. (Enter nature of injury in F   | Port I or Port 11 of item 18.)  |                               |  |  |
| U (IF EITHER, NOTIF                  | Y MEDICAL EXAMINER)  |                               |                                   |   |                               |  |  |
|                                      |  | d. INJURY OCCURRED 20e. PL    | ACE OF INJURY (Home, form         | , 20f. (City or town)   | (County) (State)              |  |  |
| Hour a. m                            |  | hile Not while fo             | ctory, street, office bldg., etc. | )   | (0.0.0)                       |  |  |
|                                      |  |                               | 2 50 0                            |   |                               |  |  |
| 21. I certify                        | that I attended the dec  | eased fram Deptember          | 1, 1959, to Se                    | ptember 12 19 59 that I   | last saw the deceased         |  |  |
| alive an SET                         | otember 12 , 1   | 2.22, and that death          | accurred at 10:30                 | P.M. fram the causes and on   | the date stated above         |  |  |
|                                      | 0 0 1.   |                               |                                   | ADDRESS (Street, city or town, stote)   | DATE SIGNED                   |  |  |
| SIGNATURE                            | John f. a  | 5 M                           | M.D. The Clinica                  | al Center   | 9/13/59                       |  |  |
|                                      |  | X                             |                                   | nstitutes of Healt  | h                             |  |  |
| PHYSICIAN'S<br>NAME (Type)           | JOHN P. UTZ.   | M.D.                          |                                   | Maryland  | 11                            |  |  |
| 220. BURIAL, CREMATI                 |  | 22c. NAME OF CEMETERY O       |                                   |   |                               |  |  |
| REMOVAL (Specif                      | y) ,   |                               |                                   | 22d. LOCATION (City, town, or county)   |                               |  |  |
| Burial                               | 9/16/59  | Arlington                     |                                   | Arlington, Vi   |                               |  |  |
| 23. FUNERAL DIRECTO                  |  | ADDRESS                       |                                   | D BY REGISTRAR'S S  | - 4 .                         |  |  |
| Robert                               | A. Pumphrey  | Betnesda,                     | Maryland SI                       | EP 15'59   Circling   | & Thous                       |  |  |

death. Page

| MAKI   | LAND             | SIAIE DEPARTM              |  |                           | IIMOKE, I                         | 8              | 10.        | 337                 |
|--|------------------|----------------------------|--|---------------------------|-----------------------------------|----------------|------------|---------------------|
| 103  | 387              | CERTIFICA                  | ATE OF DEAT                                    | Н                         |                                   | Reg. Dist.     | No.        |                     |
| 1. PLACE OF DEATH o. COUNTY Montgomery   |                  | , MARYLAND                 | 2. USUAL RESIDENCE (W<br>o. STATE<br>West Virg |                           | d lived. If institution b. COUNTY | n: Residence I | pefore adm | ission)             |
| b. CITY OR TOWN (If outside corporate lim<br>RURAL and give nearest town)<br>Bethesda          | its, write       | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (IF                            | outside corpo             |                                   | RAL and give   | nearest to | x-3                 |
| d. NAME OF HOSPITAL (If not in hospital, sor INSTITUTION  The Clinical Cente                   |                  | address)                   | d. STREET ADDRESS                              |                           |                                   |                | ON         | ESIDENCE<br>A FARM? |
| 3. NAME OF Fin   | _                | Middle<br>Jane             | losi<br>Blair                                  | 4. DATE<br>OF<br>DEATH    | Month<br>Septem                   |                | Doy<br>1.  | Year<br>19 59       |
| S. SEX Female 6. COLOR OR RACE White   | 7. MARI<br>WIDOW |                            | 8. DATE OF BIRTH August 12,                    | CATEGORIA CONTRACTOR      | 9. AGE (In years                  | Months Da      |            | DER 24 HRS.         |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired Child    | done 10b.        | None                       |  | e ar foreign co<br>Virgin |                                   |                | J. S.      | A COUNTRY           |
| 13. FATHER'S NAME Perry D. Blair   |                  |                            | 14. MOTHER'S MAIDEN                            |                           |                                   |                |            |                     |
| 15. WAS DECEASEDEVER IN U. S. ARMED FOR (Yes, no. or unknown)  (If yes, give war or dates of s |                  | 37                         |  | dical                     | Record Addre                      |                | Maryl      | Land                |
| 18. CAUSE OF DEATH [Enter only one con PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o         | Co               | ne for (a), (b), and (c).] |  |                           |                                   | li li          | INTERVAL I | 8ETWEEN             |
| 2043 DUE TO  |                  | ute Leukemia w             | ith Pancyton                                   | enia                      |                                   |                | 7 M        | onths               |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. CERTIFICATION WAS AUTOPSY PERFORMED? YES NO Septicemia 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a. m. While Not while at work p. m 1959, ta September 1, 1959, that I last saw the deceased 21. I certify that I attended the deceased fram

and that death accurred at 11.10PM, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL The Clinical Center National Institutes of Health

PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D. Bethesda 14. Maryland 22b. DATE THEREOF 22d. LOCATION (City, town, oracounty

22c. NAME OF CEMETERY OR CREMATORY

24a. REC'D BY REGISTRAR

gave rise to immediate

cause (a), stating the under-

lying cause last.

**DUE TO** 

(County)

(State)

VS A15 (4) 1SM 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE. 18

The transfer materials of the first materials and

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Crithun & Krous

|               |  | 10345  | CERTIFICA   | AIE OF DEATH   |  | Reg. Dist.        | No.  |
|---------------|--|--|---|--|--|-------------------|--|
| 1.            | PLACE OF DEATH   | tomery   | MARYLAND  | 2. USUAL RESIDENCE (WHO a. STATE Mary                          | nere deceased lived. If ins                    | NTY A.            | before admission)  |
| )             | b. CITY OR TOWN (If o<br>RURAL and give near                         |  | ite c. LENGTH OF STAY IN 16                                   | c. CITY OR TOWN (IF)   | Sover  | ite RURAL and giv | e nearest town)  |
|               | d. NAME OF HOSPITAL<br>OR INSTITUTION                                | (If not in hospital, give sta                                  | um and dapital  | d. STREET ADDRESS  | Gardine  | r are.            | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                                |
| 3.            | NAME OF<br>DECEASED<br>(Type or print)                               | alfred   | E IIIS  | Bowers   | 4. DATE<br>OF<br>DEATH Se                      | Manth<br>bt. 2    | Day Yeor 1959  |
| 5.            | Male   | 1 1 1  | MARRIED NEVER MARRIED DIVORCED DIVORCED                       | 8. DATE OF BIRTH   | 9. AGE (In your lost birthd                    | ay) Months D      | YEAR IF UNDER 24 HRS   |
|               | during mast of warking   | (Give kind of wark dane<br>g life, even if retired)            | 106. KIND OF BUSINESS OR INDU                                 | JSTRY 11. BIRTHPLACE (State                                    | N  | 12. CITIZE        | S. W   |
| 13.           | James T  | R. Bowers  | , Sr.   | Winifred   | KACKKOKX                                       | HUTCHESO          | N  |
|               |  | N U. S. ARMED FORCES?<br>yes, give wor or dates of service)    | 16. SOCIAL SECURITY NO.                                       | was hington  | Sanitarian                                     | Address Nos       | pital .  |
|               | PART I. DEATH  | WAS CAUSED BY: WMEDIATE CAUSE (6)  DUE TO  , which (b) nediale | or line for (a), (b), and (c).]  Oronary  Lionic Con          | Thrombo<br>onaver Ark  | sis<br>ery Disea                               | vnde              | INTERVAL BETWEEN ONSET AND DEATH S A A A A A A A A A A A A A A A A A A |
| CERTIFICATION | 20a. ACCIDENT WAS  | UNDERLYING 20b.  | NS CONTRIBUTING TO DEATH BU                                   |  |  |                   | 1(o) 19. WAS AUTOPSY PERFORMED? YES NO                                 |
| MEDICAL C     | (IF EITHER, NOTIFY MI<br>20c. TIME OF INJURY<br>Hour o. m.<br>p. m.  | Manth, Day, Year 20  | od, INJURY OCCURRED 20e. Pl<br>hile Not while<br>wark of wark | ACE OF INJURY (Hame, farm<br>actory, street, affice bldg., etc | 20f. (City ar tawn)                            | (Car              | unty) (Stote   |
|               | 21. I certify that glive an ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | I attended the dec   | 121   | 41   | M, fram the causes ADDRESS (Street, city or to | and an the        | saw the deceased<br>date stated above<br>DATE SIGNEE                   |
| 220           | BURIAL, CREMATION,<br>REMOVAL (Specify)                              | 226-DATE THEREOF<br>9/23/59                                    | 22c. NAME OF CEMETERY C                                       | OR CREMATORY  CEMETERY   | 22d. LOCATION (City, to<br>Prince Geo.         |                   | (State)  |
| 23            | FUNEDAL DIRECTOR'S   | ICNIATURE DALL -   | 17 14 Rosenece  | - 2000 01 050  | D DV DECICTRAD 24h I                           |                   |  |

e funeral directar, and 2 shauld be filed with death. Page by the haspital or attending physician.

CIOR: After this certificate has been signed by the attending physician and campletely filled in by a detached for use as the burial-transit permit. Then please remave corban poper. Pages 1 and 2 reto burial, crematian, ar removal, and in any event within 72 hours after death ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haur TO HOSPITAL OF AT may be retain by TO FUNERAL CT. page 3 shauld be do the registrar prior to

VS A15 (4) 15M 9/58

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THE REPORT OF THE PROPERTY OF

10389 CERTIFICATE OF DEATH

Reg. Dist. No.

10341

|   | 7,0003  |                                       |   |                         |                                     |   |
|---|---|---------------------------------------|---|-------------------------|-------------------------------------|---|
|   | 1. PLACE OF DEATH a. COUNTY MOTEOMERA   | MARYLAND                              | 2. USUAL RESIDENCE (Who STATE                                 | Ь.                      | If institution: Reside              | ence before odmission)  GONERG                |
| ) | b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  | c. LENGTH OF STAY IN 16               | c. CITY OR TOWN (IF o   |                         | its, write RURAL ond                | give nearest tawn)                            |
| 4 | d. NAME OF HOSPITAL (If not in haspital, give street of ORINSTITUTION  SUBURBAN HOSPI   | address)                              | d. STREET ADDRESS   | tunT                    | Avenu                               | e. IS RESIDENCE<br>ON A FARM?<br>YES NO       |
|   | 3. NAME OF DECEASED (Type or print)  Benjamir   | Middle  AGEE                          | BONLES  | 4. DATE<br>OF<br>DEATH  | Manth<br>9                          | Day Year 16 1959                              |
|   | 5. SEX 6. COLOR OR RACE 7. MARR MALE WHITE WIDOWE   | LED EN THE TEXT MANAGES               | B. DATE OF BIRTH  | 9. AGE<br>last          | (In years birthday)  7 yrs. IF UNDE | R 1 YEAR IF UNDER 24 HRS Des Hours Min.       |
|   | 10c. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)  | KIND OF BUSINESS OR INDUS             | STRY 11. BIRTHPLACE (State                                    | ar fareign country)     | 12. CI                              | TIZEN OF WHAT COUNTRY?                        |
|   | 13. FATHER'S NAME  XNAXXNWILLIAM Bowles   | S                                     | 14. MOTHER'S MAIDEN N   | nora                    | Agee                                |   |
|   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)   | 1/                                    | ARJORIE H.  | BowlE.                  | S S                                 | an E  |
|   | 1B. CAUSE OF DEATH [Enter only one couse per lin PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   | ne far (a), (b), and (c).]  ETASTATIC | CARCINOMA   |                         |                                     | INTERVAL BETWEEN ONSET AND DEATH 3 M W THS    |
|   |   | RCINOMA 7                             | STOMACH   | 0.30                    |                                     | 3 months                                      |
|   | gove rise to immediate cause (o), stating the <u>under-lying cause lost.</u>   DUE TO   Column   Column |                                       |   |                         |                                     |   |
| ) | PART 11. OTHER SIGNIFICANT CONDITIONS C   | ONTRIBUTING TO DEATH BUT              | NOT RELATED TO THE TERMI                                      | nal disease cont        | DITION GIVEN IN PA                  | PERFORMED?  YES NO                            |
|   | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | CRIBE HOW INJURY OCCURRE              | D. (Enter noture of injury in I                               | Port I or Port II of it | tem 1B.)                            |   |
|   | 20c. TIME OF INJURY Month, Day, Yeor 20d. IN Haur a. m. While of world w  | Not while fac                         | ACE OF INJURY (Hame, farm<br>ctary, street, office bldg., etc |                         | n)                                  | (County) (State                               |
|   | 21. I certify that I attended the decease alive an  | ~ //                                  |   | M, fram the co          | auses and an t                      | last saw the deceased<br>ne date stated abave |
|   | ACTUAL SIGNATURE QUE O COMMA  | n mo                                  | M.D. 5016   | ADDRESS (Street, ci     | ty ex tawn, state)                  | 9/19/59                                       |
| / | PHYSICIAN'S LEO I O   | ONOVAW M                              | n (   | Betherl                 | mayer                               | 1   |
|   | BEFORM Specify) 22b. DATE THEREOF 9-19-59   | 22c. NAME OF CEMETERY O               |   | Washing                 |                                     | C.  |
|   | 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                               |   | D BY REGISTRAR          | 24b. REGISTRAR'S                    |   |
|   | Robert A. Pumphrey, B   | ethesda, Mai                          | ryland DATES  | 21 '59                  | Orthun &                            | Throat  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs offer death. Page 4 may be retain by the haspitol or attending physician.

TO FUNERAL D. TOR: After this certificate has been signed by the attending physician and completely filled in by my funeral director, page 3 should be detached far use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar remayal, and in any event within 72 haurs after death.

O E O C VS A15 (4) 15M 9/5B 10389 CERRICATE OF BEATH

Robert A. Pemphrey, Bothesen, Enryland on Fill Frie

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|---|--|---|---|---|
| may be retain by the haspital or attending physician. | 50 TO FUNERAL DESCRIPTION: After this certificate has been signed by the attending physician and campletely filled in by Trife funeral director, | page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filled with | the registrar priar to burial, cremation, ar remaval, and in any event within 72 haurs after death. |   |
| etair   | AL D.  | hauld be  | rar priar   |   |
| may be r  | O FUNER  | page 3 s  | the regist  |   |
| A   | 15 /   | 4)  |   |   |
| M   | 9/5  | 2   |   |   |

PLACE OF DEATH

OR INSTITUTION

a. COUNTY

NAME OF

DECEASED

(Type or print)

EFMALE

13. FATHER'S NAME

ECOPRO

lying cause last.

PHYSICIAN'S

NAME (Type)

23. FUNERAL DIRECTOR'S SIGNATURE

CAL

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10342 **CERTIFICATE OF DEATH** 10390 Rea. Dist. No 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND MONTGOMERY MARGLAND b. CITY OR TOWN (If autside carporote limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) SHRS. 20MINS THESDA d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2020 GLENROSS YES NO SUBURBAN First Middle 4. DATE Manth Day Year LURA DEATH 195 6. COLOR OR RACE B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED 9. AGE (In years last birthdoy) Months WHITE WIDOWED | DIVORCED | 65 yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) OUST-WIFE 14. MOTHER'S MAIDEN NAME IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO INFORMANT Address HUSBAND ves nive war or dates of service SAME AS ABOUT SORGE L. 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate DUE TO cause (a), stating the under-PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 18.) 20c. TIME OF INJURY Manth, 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) Doy, Year 20d. INJURY OCCURRED (State) (Caunty) foctory, street, office bldg., etc.) While Nat while at wark at wark Ithat I last saw the deceased and that death accurred at A-\_\_M, from the causes and an the date stated abave ADDRESS (Street, city or lawn, state) ORGE

Hour o. m. 21. I certify that I attended the deceased fram.\_\_e ACTUAL SIGNATURE

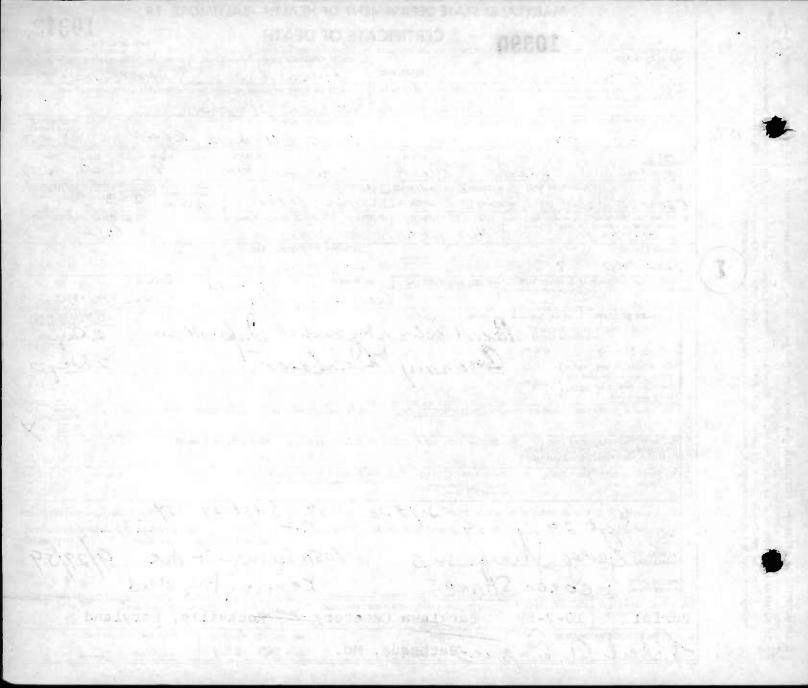
22b. DATE THEREOF 22a. BURIAL, CREMATION. 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 10-2-59

**ADDRESS** 

-Bethesda, Md.

22d. LOCATION (City, tawn, or caunty) Rockville, Maryland

24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE DE Critical & House



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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

| 10344 | 1 | () | 3 | 4 | 4 |
|-------|---|----|---|---|---|
|-------|---|----|---|---|---|

|   |   | 91             | CEICIII                          | IOAI                 | L OI DEAII   |                        |                                      | Reg. Dist.   | No.                      |                    |
|---|---|----------------|----------------------------------|----------------------|--|------------------------|--------------------------------------|--------------|--------------------------|--------------------|
|   | fontgomery  |                | MARYL                            | AND                  | usual residence (Wo. STATE Maryl                     | 2011                   | l lived. If institution b. COUNTY    |              | before admis             | sian)              |
| RURAL ond give no   | f autside carporate limits, earest tawn) 1ersburg                     | write c. LEN   | 12 yea                           |                      | c. CITY OR TOWN (IF                                  |                        | rate limits, write RU                | JRAL and giv | e nearest taw            | n)                 |
| d. NAME OF HOSPIT   | AL (If not in hospital, give Methodist Hol                            | street address |                                  |                      | of: 697 G  | ladsto                 | one Ave.                             |              | ON                       | SIDENCE<br>A FARM? |
| B. NAME OF<br>DECEASED<br>(Type or print)                         | First<br>Virginia   | Le             | Middle<br>ee Bro                 | ughto                | Lost<br>N  | 4. DATE<br>OF<br>DEATH | Septembe:                            |              | Doy<br>26,               | Year<br>19 59 •    |
| Female  |   |                | NEVER MARRIE                     |                      | June 22, 18  |                        | 9. AGE (In years lost barthday) yrs. |              | YEAR IF UND<br>ays Hours |                    |
| 0o. USUAL OCCUPATIO   | ON (Give kind af wark dar<br>king life, even if retired)<br>MONE NONE | e 10b. KIND (  | OF BUSINESS OF                   | R INDUSTRY           | Virginia   | e ar foreign co        | ountry)                              |              | U. S.                    |                    |
| 3. FATHER'S NAME  |   |                |                                  | 1                    | 4. MOTHER'S MAIDEN                                   |                        |                                      |              |                          | 75.45              |
| James I   | Broughton   |                |                                  |                      | Eliza Ann E  | 13128 C                | reen                                 | 100          |                          | <b>-</b> YA 1      |
|   | R IN U. S. ARMED FORCE<br>(If yes, give war or dates of servi         |                | L SECURITY NO.                   | 17. INFO             | Clarence   | H. Gre                 | Addr<br>en - 5220                    |              | airfax                   | Ave.               |
| gave rise to i cause (a), stating lying cause last.  PART II. OTH | DITE TO   | IONS CONTRI    | BUTING TO DEA                    | TH BUT NO            | OT RELATED TO THE TERM                               | AINAL DISEASI          | E CONDITION GIV                      | EN IN PART 1 | (o) 19. WAS              | AUTOPSY<br>ORMED?  |
| PART II. OTH  | AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)                       | b. DESCRIBE F  | 10W INJURY OC                    | CCURRED. (           | Enter noture of injury in                            | Port I or Port         | t II of item 18.)                    |              | YES                      | ] NO []            |
| 20c. TIME OF INJUR<br>Hour a. m.<br>p. m.                         | Y Manth, Day, Year<br>19  |                | OCCURRED<br>Nat while<br>It wark | 20e. PLACE<br>factor | OF INJURY (Home, fare<br>y, street, affice bldg., et | m, 20f. (City<br>c.)   | or town)                             | (Ca          | unty)                    | (Stote)            |
| 21. I certify the alive an9  ACTUAL SIGNATURE                     | lanah E Sarah E. Gl   | 1959<br>L      | and that                         | death ac             | 1956, to 9<br>coursed at 7.1/2<br>10128 (            | ADDRESS (SI            | n the causes a treet, city ar town,  | nd an the    |                          |                    |
| 220. BURIAL, CREMATIC<br>REMOVAL (Specify)                        |   |                | NAME OF CEME                     |                      |  | 1                      | TION (City, town, o                  | or county)   | (Sto                     | ite)               |
| 23. FUNERAL DIRECTOR  | S SIGNATURE   |                | ADDRESS JOE                      | 4-1                  | SA ( 1) 24a. REC                                     | D BY REGIST            | RAR 24b. REGIS                       | TRAR'S SIGN  |                          |                    |

|            | E OF DEATH   | CERTIFICAT             |
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VS A15 (4) 15M 10/57

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10392 CERTIFICATE OF DEATH

Reg. Dist. No.10345

|                                       |  |                |                         |                               |  | magi bist. ITO.                             |
|---------------------------------------|--|----------------|-------------------------|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY        |  |                | MARYLAND                | O. SIAIE                      | (Where deceased lived. If institut<br>b. COUNTY      | ion: Residence before admission)            |
| b. CITY OR TOWN                       | Ontgendry  I (If outside corporate lim                 | nits, write    | c. LENGTH OF STAY IN 16 |                               | of Columbia<br>(If outside corporate limits, write l | RURAL and give nearest town)                |
| RURAL ond give                        |  | 55.            | 112 days                | The state of the state of     |  | v 2   |
| d. NAME OF HOS                        | PITAL (If not in hospital,                             | give street oc | idress)                 | d. STREET ADDRESS             |  | e. IS RESIDENCE                             |
| OR INSTITUTION                        |  | Bath           | asda Ili. Md.           | 5911 Dick                     | Church W.B.  | ON A FARM? YES NO                           |
| 3. NAME OF                            |  | rst .          | Middle                  | lost                          | 4. DATE Mon  |   |
| (Type or print)                       |  | ssie           | Lee                     | Brown                         | OF DEATH September                                   |   |
| 5. SEX                                | 6. COLOR OR RACE                                       | 7. MARRIE      | NEVER MARRIED           | B. DATE OF BIRTH              | 9. AGE (In years lost birthday)                      |   |
| Fenale                                | Negre  | WIDOWED        | DIVORCED [              | September 1                   | 19, 1903 56 yrs.                                     | Months Doys Hours Min.                      |
| 10a. USUAL OCCUPA<br>during most of w | TION (Give kind of work rorking life, even if retired  | done 10b. K    | IND OF BUSINESS OR INDI | JSTRY 11. BIRTHPLACE (SE      | ote or foreign country)                              | 12. CITIZEN OF WHAT COUNTRY                 |
| Cook                                  |  |                | estaurant               | Virgini                       | i.e  | U. S. A.                                    |
| 13. FATHER'S NAME                     |  |                |                         | 14. MOTHER'S MAIDE            | N NAME   |   |
| Rebert 1                              |  |                |                         | Alice Tay                     | lor  |   |
| 15. WAS DECEASED E                    | VER IN U. S. ARMED FO                                  | RCES? 16. SC   | OCIAL SECURITY NO. 17.  | INFORMANT The Me              | dical Record, Add                                    | iress                                       |
| No                                    | (ii yes, give wor or outer or                          |                | certainable             |                               | Center, Bethes                                       |   |
| 18. CAUSE OF D                        | EATH [Enter only one c                                 | ouse per line  | for (o), (b), and (c).] |                               |  | INTERVAL BETWEEN                            |
| PART I. D                             | PEATH WAS CAUSED BY:                                   | Resp           | iratory Fail            | ire. Pumonar                  | y Edema, Acute                                       | ONSET AND DEATH                             |
| 171X                                  | DUE TO   |                |                         | 209 2 44.101.144              | y manney mound                                       | 15 Minutes                                  |
| Curtification                         |  | 100            |                         |                               |  |   |
| Conditions, if                        | immediate  |                | static Carci            | noma, Pulmon                  | ary & Anemia; U                                      | remia 3-5 Weeks                             |
| couse (o), slotin                     | ng the under DUE TO                                    |                |                         |                               |  | ruction.                                    |
| lying couse los                       |  |                |                         |                               | nd Bilateral Ut                                      |   |
| PART II. C                            | THER SIGNIFICANT CON                                   | ADITIONS CO    | INTRIBUTING TO DEATH BU | T NOT RELATED TO THE TE       | RMINAL DISEASE CONDITION GIV                         | VEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? |
| <u> </u>                              |  |                |                         |                               |  | YES 🙀 NO 🗌                                  |
| OR CONTRIBUTION                       | WAS UNDERLYING  NG CAUSE OF DEATH FY MEDICAL EXAMINER) | 20b. DESCR     | IBE HOW INJURY OCCURR   | ED. (Enter noture of injury   | in Port I or Port II of item 18.)                    |   |
| 20c. TIME OF INJI                     | URY Month, Day, Ye                                     | ar 20d, INJ    | URY OCCURRED   20e. P   | LACE OF INJURY IHome, for     | orm, 20f. (City or town)                             | (County) (State)                            |
| Hour a.m                              | 10   | While          | Not while for           | octory, street, office bldg., | etc.)  |   |
|                                       |  |                |                         | - 40                          |  |   |
| 21. I certify                         | that I attended the                                    | deceased       | from June 9,            | , 19.59_, to_s                | September 29,1959                                    | L.,that I last saw the decease              |
| alive on Say                          | ptember 29,  | 112-59         | 2 and that deat         | accurred at 12:44             |  | and an the date stated above                |
| ACTUAL                                | () /   | KX             | 16                      |                               | ADDRESS (Street, city or town,                       | stote) DATE SIGNE                           |
| SIGNATURE                             | Ma   | 120            | 21/1                    | M.D. The Clin                 | ical Center  | 9/30/59                                     |
| PHYSICIAN'S                           |  |                |                         | National                      | Institutes of  | Health                                      |
| NAME (Type)                           | ALAN B. RE   |                | M.D.                    |                               | Ill, Maryland  |   |
| 220. BURIAL CREMAT                    | ION, 226. DATE THERE                                   |                | 22c. NAME OF CEMETERY   | REMATORY                      | 22d. LOCATION (City, town,                           | orgcounty) /7 (Stole)                       |
| REMOVAL (Specif                       | 10-3-  | 59             | Wood                    | laun.                         | 11/00  | hinton D.C.                                 |
| 3. FUNERAL DIRECTO                    | R'S SIGNATURE  |                | ADDRESS                 | 24a. R                        | EC'D BY REGISTRAR 24b. REGI                          | STRAR'S GNATURE                             |
| Francis                               | Funeral  | Hon            | 4.389-R.J.              | aw. new GATE                  | 2 159  | 1 d. / come                                 |
| 1 /0 //00 /00                         | 1/10000  | . 4            | - 0 0 1 - 1 C 1         | DALE                          |  |   |

# TO SER U SERTICALE OF DEATH

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death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10346

| L             |  | 10393                                 | CERTII                    | FICATI                   | OF DEAT   | П                      |                                    | Reg. Dist.     | No.            |                       |
|---------------|--|---------------------------------------|---------------------------|--------------------------|---|------------------------|------------------------------------|----------------|----------------|-----------------------|
| 1.            | PLACE OF DEATH o. COUNTY   |                                       |                           |                          | USUAL RESIDENCE (Vo. STATE                      | Vhere decease          |                                    | n: Residence l | pefare admissi | ion)                  |
|               | Montg  | omery                                 | MARYI                     | LAND                     | West  | Virgin                 | ia b. COUNTY                       | Samuel         | cxRaded        | E                     |
| 1             | b. CITY OR TOWN (If outside corp<br>RURAL and give nearest town)  Gaithersburg               |                                       | c. LENGTH OF STAY I       | IN 1b                    | c. CITY OR TOWN (II                             | outside corpo          |                                    | JRAL and give  | nearest town   | )                     |
| -             | d. NAME OF HOSPITAL (If not in h   |                                       | ddress)                   |                          | d. STREET ADDRESS                               | re Lett                | 10 8                               | J X            | e. IS RESI     | IDENCE                |
| A             | sbury Methodist  | Home for                              | the Aged,                 | Inc                      |   |                        |                                    |                |                | PARM?                 |
| 3.            | NAME OF DECEASED (Type or print) GERTA   | RUDE                                  | Middle                    |                          | BROWN   | 4. DATE<br>OF<br>DEATH | Sep                                | 7              |                | Yeor<br>19 <i>5</i> 9 |
| S.            | SEX 6. COLOR C   | OR RACE 7. MARRI                      | ED NEVER MARRIE           | D 8. D                   | TE OF BIRTH                                     | 371                    | 9. AGE (In years<br>last birthday) | IF UNDER 1 Y   |                |                       |
|               | Female Whi   |                                       | _                         |                          |   |                        | 817 yrs.                           | Months Da      | 4              | Min.                  |
|               | a. USUAL OCCUPATION (Give kind during most of working life, even HOUSEWITE                   | it retired)                           | CIND OF BUSINESS OF       | R INDUSTRY               | Jefferson                                       |                        |                                    |                | N OF WHAT      | COUNTRY?              |
| 13            | . FATHER'S NAME  | 1 22                                  |                           | 14                       | . MOTHER'S MAIDEN                               |                        | West va.                           | 1 0.           | S. A.          |                       |
|               | Thomas Broth   | erton                                 |                           |                          |   | Jane S                 | Spotts                             |                |                |                       |
|               | . WAS DECEASED EVER IN U. S. AR  | MED FORCES? 16. S                     | OCIAL SECURITY NO.        | 17. INFOR                |   |                        |                                    | ess Dogo       | md a           |                       |
|               | as. no. or unknown) (IT yes, give wor (  | or dates of service)                  |                           |                          | aspury e  | 3 61100                | Gaithe                             |                |                |                       |
|               | 18. CAUSE OF DEATH [Enter on   |                                       | e for (o), (b), and (c).) |                          | -, -  |                        |                                    |                | INTERVAL BET   |                       |
|               | PART I. DEATH WAS CAU  | CAUSE (o)                             | reproduction              | V en                     | Saulia  | 1                      |                                    |                | SINSEL AND     | DEATH                 |
|               | 420.1  | DUE TO                                | 9                         |                          |   |                        |                                    | ,              |                |                       |
| 1             | Conditions, if ony, which )  | (b) h                                 | ull-ten                   | 45                       | calin   | ma                     | carle d                            |                |                |                       |
|               | gove rise to immediate   | DUE TO                                | 4                         |                          |   |                        |                                    |                |                |                       |
|               | lying cause lost.  | (c)                                   |                           |                          |   |                        |                                    |                |                |                       |
| Z             | PART II. OTHER SIGNIFICA   |                                       | ONTRIBUTING TO DEA        | TH BUT NOT               | RELATED TO THE TER                              | MINAL DISEAS           | E CONDITION GIVI                   | EN IN PART 16  | 0) 19. WAS A   | AUTOPSY               |
| SATE          |  |                                       |                           |                          |   |                        |                                    |                | PERFO          | RMED?                 |
| CERTIFICATION | 20g. ACCIDENT WAS UNDERLYIN<br>OR CONTRIBUTING [] CAUSE OF<br>(IF EITHER, NOTIFY MEDICAL EXA | IG [] 20b. DESC<br>F DEATH<br>(MINER) | RIBE HOW INJURY OC        | CCURRED. (En             | ter nature of injury in                         | Port I or Par          | t II of item 18.)                  |                |                |                       |
| MEDICAL       | 20c. TIME OF INJURY Month, I   | While                                 | JURY OCCURRED  Not while  | 20e. PLACE (<br>foctory, | OF INJURY (Home, far<br>street, office bldg., e | rm, 20f. (City         | or town)                           | (Cou           | nty)           | (State)               |
| A.            | p. m.  | 19 of work                            | at work                   |                          |   |                        |                                    |                |                |                       |
|               | 21. I certify that I attend  | led the decease                       | d from 8-                 | 8                        | , 1956, ta                                      | 9 1                    | 6 , 1958                           | that I las     | t saw the      | deceased              |
|               | alive an Sept 1  | 6 , 195                               | 4, and that               | death acc                | urred at 1:48                                   | PM. fran               | n the causes a                     | nd on the      | date state     | d abave               |
|               | 1. 0   | . 1.1                                 |                           |                          |   |                        | treet, city or town, s             |                |                | TE SIGNED             |
|               | ACTUAL SIGNATURE   | 2 14/0                                | me-                       | MD                       | 10128 0   | Edpi                   | 2 LANS                             |                | 9-11           | -50                   |
|               | Steel Aller Steel  |                                       |                           |                          |   |                        | 70w, m                             | /              |                |                       |
| L             | PHYSICIAN'S Sarah E  | . Glover,                             | M.D.                      |                          |   |                        |                                    |                |                |                       |
| 22            |  | E THEREOF                             | 22c. NAME OF CEME         |                          | MATORY  | 22d. 19CA              | TION (City, town,                  | r county)      | (Stote         | )                     |
|               | Sprial 9-1   | 19-57                                 | green 1                   | Till.                    |   | Ber                    | ryville                            |                | Va             | 2                     |
| 23            | FUNERAL DIRECTOR'S SIGNATURE   | 1 +                                   | ADDRESS                   | 1                        | 240. REC  | D BY REGIST            |                                    | TRAR'S SIGNA   |                |                       |
| 1             | smesh &  | tastre                                | - Jaithes                 | obur                     | 9 PANDATE                                       | OEF 18                 | 20 C                               | nthung & s     | Traud          | Y THE                 |

TO HOSPITAL OR VS A15 (4) 1SM 10/S7

Sep7 16 59 GERTRUGE BROWN THE PROPERTY OF THE PARTY OF TH | Interestate nyrodol sofontin 15 4 16 28 with 1: 48 place be an entired as de Colored as the Lanole E Glone 10128 CEDAR LANE 65-11-6 NENSING 7cm, mil . T. M. ANDERS C. C. CO. OFFICE AND CO.

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Give Pages 1, 2, 43. Page 5 may k ede, writing the wara penamy in personal form PM3. Chief Medical Examiner's Office along with form PM3. be used as a burial-transit O DEPUTY MEDICAL EXAMINER: This certificate should be CTOR: Page 3 shauld cute the cert farwarded TO FUNERAL

|  | 1. PLACE OF DEATH 0. COUNTY  | 1000   | 4                          |                         | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)  a. STATE b. COUNTY |                |   |           |         |           |            |
|--|--|--|----------------------------|-------------------------|---|----------------|---|-----------|---------|-----------|------------|
| -  |  | tgomery  |                            | MARYLAND                | Md. Montgomery  |                |   |           |         |           |            |
|  | and give neatest fown  |  | RURAL C. LENC              | OTH OF STAY IN 16       | c. CITY OR TOWN   | (If outside co | rporate limits, write   | RURAL and | give no | earest to | wn)        |
| Brinklow Olney 33 hrs. X Brinklow, Rt. 116   |  |  |                            |                         |   |                |   |           |         |           |            |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)  Montgomery County General Hosp. Inc. |  |  |                            |                         |   |                |   |           | ON      | A FARM?   |            |
| 3. NAME OF First Middle  |  |  |                            |                         |   | 4. DATE        | 44  |           |         |           |            |
| Į  | ·DECEASED<br>(Type or print)   |  |                            |                         | Last  | OF             |   |           |         |           |            |
|  | S. SEX   | 6. COLOR OR RACE   |                            | Leroy EVER MARRIED [ 8. | Brown<br>DATE OF BIRTH  | DEATH          |   |           |         |           | -          |
| ľ  | Male   |  | WIDOWED T                  | DIVORCED T              |   |                | last birthday)  | -         |         | Hours     | Min.       |
|  |  | ON (Give kind of work do   |                            |                         | 2/11/99   | ta an familia  |   | la ciri   | 7551 05 | 14/1147   | COUNTR     |
|  | during most of working   | ig life, even if retired)  | JIN TOO. KIND OF           |                         |   |                |   |           | WHAI    | COUNIK    |            |
|  |  |  |                            |                         |   |                |   | 3 30      |         |           |            |
|  |  | PISC   |                            |                         |   |                | The same  | US        | A       |           | -          |
|  | 13. FATHER'S NAME  |  |                            |                         | 14. MOTHER'S MAIDEN   | NAME           |   | US        | SA      |           |            |
|  | 13. FATHER'S NAME Harry B  | rown   | CESS 14 SOCIALS            | ECHRITY NO. 17 A        | 14. MOTHER'S MAIDEN Maude   | NAME           |   |           | SA      |           |            |
|  | 13. FATHER'S NAME  Harry B 15. WAS DECEASED EVI  |  |                            | רושו                    | 14. MOTHER'S MAIDEN Maude FORMANT   | Johns          | Address   |           |         |           |            |
| -  | Harry B  15. WAS DECEASED EVI (Yes. Nounknown)   | TOWN  ER IN U. S. ARMED FOR( (If yes, give wor or doles of se  | " Unkno                    | WIL                     | 14. MOTHER'S MAIDEN Maude   | Johns          | Address   |           | 7, M    |           |            |
| -  | Harry B 15. WAS DECEASED EVI (Yes. n) Whitnown)  18. CAUSE OF DEAT   | TOWN ER IN U. S. ARMED FORG (If yes, give wor or dates of se TH [Enter only one cause  | Unkno                      | ), ond (c). ]           | 14. MOTHER'S MAIDEN Maude FORMANT   | Johns          | Address   |           | INTERN  | VAL BETWE | EEN<br>ATH |
| -  | Harry B 15. WAS DECEASED EVI (Yes. n) Whitnown)  18. CAUSE OF DEAT   | TOWN  ER IN U. S. ARMED FOR( (If yes, give wor or doles of se  | Unkno                      | WIL                     | 14. MOTHER'S MAIDEN Maude FORMANT   | Johns          | b. COUNTY Montgomery ide corporate limits, write RURAL and give nearest town)  7, Rt. 116  e. IS RESIDENCE ON A FARM? YES NO S  DEATH Month Day Year PEATH September 18 19 59  9. AGE   In years   IF UNDER 1YEAR   IF UNDER 24 HR: authority   Months Days Hours Min.  Foreign country)  12. CITIZEN OF WHAT COUNTR  USA |           |         |           |            |
| -  | Harry B 15. WAS DECEASED EVI (Yes. n) Whitnown)  18. CAUSE OF DEAT   | TOWN  ER IN U. S. ARMED FORG (If yes, give wor or doles of se  TH [Enter only one causa TH WAS CAUSED BY:  | unkno per line for (a), (b | ), ond (c).]            | Maude Mormant Hospital  | Johns<br>Recor | Address<br>ds (   | Olney     | INTERN  | AND DE    | hrs        |
| -  | 13. FATHER'S NAME  Harry B  15. WAS DECEASED EVI (Yes. "Nounknown)  18. CAUSE OF DEAT PART 1. DEAT  8/2  Conditions, if or | TOWN  ER IN U. S. ARMED FORK (If yes, give wor or dates of se  TH [Enter only one cause TH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  ny, which ) (b) | unkno per line for (a), (b | ), ond (c).]            | Maude Mormant Hospital  | Johns<br>Recor | Address<br>ds (   | Olney     | INTERN  | AND DE    | hrs        |
| -  | 13. FATHER'S NAME  Harry B  15. WAS DECEASED EVI (Yes. n Nounhown)  18. CAUSE OF DEAT PART 1. DEAT                         | ER IN U. S. ARMED FORG (If yet, give wor or doles of se  TH [Enter only one cause H WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  ny, which diote cause  | unkno per line for (a), (b | ), ond (c).]            | Maude Mormant Hospital  | Johns<br>Recor | Address<br>ds (   | Olney     | INTERN  | AND DE    | hrs        |

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Truck backed over him while attempting to close a gate 20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or tawn) (County) (Stale) While / factory, street, office bldg., etc.) Not while at work Montg Md Unity, Farm 21. I certify that I taak charge af the remains described above, held an Autapsy and find that death resulted from: Natural causes Accident | Suicide Hamicide . Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER EXAMINER'S NAME (Type) Frank J. Broschart, DEPUTY MEDICAL EXAMINER 9/18/59 22b. DATE THEREOF 220. BURIAL, CREMATION, REMOVAL (Specify) 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Slote) Sept Md **ADDRESS** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Md

DATE

Laytonsville.

SEP 2 3 '59

arthur & Hours

VS. A15ME(5) SM 9/SS

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VS A15 (4) 15M 10/57 M

10348

10395 CERTIFICATE OF DEATH

Reg. Dist. No.

| 1             | o. COUNTY  |  |               |               |                  | 2. USUAL RESI        | DENCE (WI      | here deceased  | lived. If institution           | n: Residence | before adm    | ission)   |
|---------------|--|--|---------------|---------------|------------------|----------------------|----------------|----------------|---------------------------------|--------------|---------------|-----------|
| L             | Mon  | tgomery  |               |               | MARYLAND         |                      | Mary           | land           | b. COUNTY                       | Mon          | tgome         | ery       |
|               | b. CITY OR TOWN (If RURAL and give ne  | outside carporote timi<br>arest town)<br>ev. Md. | ts, write     |               | Hrs.             | X                    |                |                | ate limits, write RI            | URAL ond giv | re nearest to | wn)       |
| -             | d. NAME OF HOSPITA   | AL (If not in hospital, g                        | ive street o  | oddress)      | Hrs.             | Jd. STREET           | Olney          | /              |                                 |              | e. IS R       | ESIDENCE  |
| 1             | Montgomer  | y County   | Gene          | eral          | Hosp.            | None.                |                |                |                                 |              |               | A FARM?   |
| 3             | . NAME OF<br>DECEASED  | Fir  | st            |               | Middle           | lo                   |                | 4. DATE        | Mon                             | th           | Day           | Year      |
|               | (Type or print)  | Katie  | Dunc          | can           | Buckle           | V                    |                | OF<br>DEATH    | Sep                             | t .          | 24.           | 19 59     |
| 5             | . SEX  | 6. COLOR OR RACE                                 |               | IED NE        |                  | 8. DATE OF BIRT      | н              | 9              | AGE /In wood                    |              | YEAR IF UN    |           |
|               | Female   | White  | WIDOWE        |               | DIVORCED [       | 6/8/                 | 767            | 8              | Jost birthdoy) yrs.             | Months D     | ays Haur      | s Min.    |
| 10            | Oa. USUAL OCCUPATIO  | N (Give kind of working life, even if retired    | done 10b. I   | KIND OF B     | USINESS OR INDU  | STRY 11. BIRTHP      | LACE (Stole    | or foreign cou | untry)                          | 12. CITIZ    | EN OF WHA     | T COUNTRY |
| Ł             |  | Housewife  |               |               |                  |                      | Viro           | rinia          |                                 |              | U.S.          | Α.        |
| 13            | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME   |  |               |               |                  |                      |                |                |                                 |              |               |           |
| I             | Elzie D  | uncan Sha  | ackel         | ford          | 1                | Ani                  | nie            | Mae B          | althro                          | pe           |               |           |
| 15            | S. WAS DECEASED EVER   | IN U. S. ARMED FOR                               | CES? 16. 9    | SOCIAL SEC    | CURITY NO. 17.   | NFORMANT             |                |                | Addr                            | -            |               |           |
| I.            | to the second se | yes, give war ar adies or s                      |               |               | F                | ospita               | 1 Rec          | cords.         |                                 |              |               |           |
| F             | 18. CAUSE OF DEAT  | TH [Enter anly one co                            | use per lin   | e for (a), (l |                  | . 0                  | Alv            |                | 0                               |              | INTERVAL      | BETWEEN   |
|               | PART I. DEAT   | H WAS CAUSED BY:                                 | Pu            | lu            | mae.             | Ele                  | v.,            | an.            | te                              |              | ONSET AN      | DEATH     |
|               | 420.1  | DUE TO   |               |               | X                |                      | 0              | 0 00           |                                 | Λ 0          | 701           |           |
|               |  | y, which )                                       | . C.          |               | au V             | Per con l            | 1.             |                | Menora                          | 1. 0         | 44 8          |           |
|               | Conditions, if ony, which gave rise to immediate couse (o), stoting the under DUE TO D |  |               |               |                  |                      |                |                |                                 |              |               |           |
|               | lying cause last.  | ne under-  | h             | Man           | class.           | + aur                | rent           | en til         | rullal                          | in           | 4 7           |           |
| Z             | PART II. OTH   | ER SIGNIFICANT CON                               |               | ONTRIBUTI     | NG TO DEATH BUT  | NOT RELATED TO       | THE TERMI      | NAL DISEASE    | CONDITION GIV                   | EN IN PART   | (a) 19. WAS   | AUTOPSY   |
| CEPTIFICATION | 5  |  |               |               |                  |                      |                |                |                                 |              | YES T         | ORMED?    |
| TIE           | 20a. ACCIDENT WAS  | UNDERLYING [                                     | 20b. DESC     | RIBE HOW      | INJURY OCCURRE   | D. (Enter noture o   | of injury in I | Part I or Port | II of item 18.)                 |              |               |           |
| 4.0           |  | MEDICAL EXAMINER)                                |               |               |                  |                      |                |                |                                 |              |               |           |
| MEDICAL       | 20c. TIME OF INJURY  | Month, Day, Ye                                   |               | JURY OCC      |                  | ACE OF INJURY        | Home, farm     | , 20f. (City   | or town)                        | (Co          | unty)         | (Stote)   |
| A P           | Hour a.m.  | 19   | While of work | Not w         | mic              | ctory, street, offic | e bldg., etc.  | .)             |                                 |              |               |           |
|               |  | at I attended the                                | decease       | d from        | 22 820           | 19.5                 | 1. ta          | 7480           | A. 1959                         | 7 11 1 1 -   |               |           |
|               | alive on 24  | Sax T  | 10 5          | - 15          | /                |                      |                |                | LA .                            |              |               |           |
|               | dive dil 35  |  | 17_34         |               | and that death   | accurred at          |                |                | Ine causes a set, city or town, |              |               | ted abave |
|               | ACTUAL<br>SIGNATURE  | Do Bo  | Dec           | ( )           | entel            |                      | 72             | 0/1            | Med                             | ,,           | 24            | 50.45     |
|               | SIGNATORE T  |  |               | X             | X                | M.D                  |                | -              | 1-1-1-                          |              |               | 29/-      |
|               | PHYSICIAN'S<br>NAME (Type)   | JOHN 1   | 3051          | ピソ            | DAVE             | G-LER                |                |                |                                 |              |               | V         |
| 27            | O. BURIAL, CREMATION   | , 226. DATE THEREC                               | F             | 22c. NAM      | NE OF CEMETERY C | R CREMATORY          |                | 22d. LOCATION  | ON (City, tawn, a               | r county)    | (Ste          | ate)      |
|               | REMOYAL (Sectify)  | 9/26/5   | 9             |               |                  | emetery              | 7              |                | Montgo                          |              | Co.,          |           |
| 23            | . FUISERAL DIRECTOR'S  | SIGNATURE A                                      |               | ADDR          |                  |                      | 240. REC'      | D BY REGISTR   |                                 | TRAR'S SIGN  |               |           |
|               | groy an  | - Ozarb  | er            | Layt          | onsvill          | e, Md.               | DATE (         | EP 2 8 '5      | 9 (1)                           | Lines &      | Kanad         |           |
|               |  |  |               |               |                  |                      | 2.50           | 50 W.          | -                               | 1 6          | - at much     |           |

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|                  | ₹n\ E\\3             |           |          |         |                       |   |
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|                  | Senta<br>Coll 186 on |           |          | ado aos |                       |   |
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TO HOSPITAL OR

VS A1S (4) 1SM 9/S8

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#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10349

|            | 10347  | CERTIFIC                                  | ATE OF DEATH   | 1                           | Reg. Dist          | . No.                               |                            |
|------------|--|---|--|-----------------------------|--------------------|-------------------------------------|----------------------------|
| 1.         | PLACE OF DEATH o. COUNTY  Montgomery   | MARYLAND                                  | 2. USUAL RESIDENCE (WHO o. STATE Mary)                       |                             |                    | Mont                                | ion)                       |
|            | b. CITY OR TOWN (If outside corporate limit, write RURAL and give nearest town)                            | c. LENGTH OF STAY IN 16                   | c. CITY OR TOWN (IF of                                       | outside corporate limits, w | vrite RURAL and gi | ve nearest town                     | 1)                         |
|            | d. NAME OF HOSPITAL (If not in hospitol, give street OR INSTITUTION  Washington San & M.                   | r oddress)                                | Bo x 507   | metzerott                   | Rd                 |                                     | IDENCE<br>FARM?            |
| 3.         | NAME OF DECEASED (Type or print)  NAME OF DECEASED (Type or print)  To seph                                | Albert                                    | Burdis   | 4. DATE<br>OF<br>DEATH      | Month              | ,                                   | Year<br>1959               |
| S.         | SEX 6. COLOR OR RACE 7. MAR  | RRIED NEVER MARRIED                       | 8. DATE OF BIRTH / 7/190                                     | 9. AGE (In lost birth       | 1                  | YEAR IF UNDE<br>Days Hours          | Min.                       |
| L          | Corponici  | KIND OF BUSINESS OR INDU<br>EN BLOG TRADE | se Va  |                             |                    | SA                                  | OUNTRY                     |
| L          | 203(2)   | sr.                                       | 14. MOTHER'S MAIDEN N  | NAME                        |                    |                                     |                            |
| 15.<br>(Ye | . WAS DECEASED EVER IN U. S. ARMED FORCES? 16 ss. no. or unknown) (If yes, give war or dates of service)   | 79-03-9370                                | INFORMANT 140 SP   | Receids                     | Address            |                                     | e de                       |
|            | PART I. DEATH Enter only one couse per I PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO           | Corona                                    | ry Occh  | sion                        |                    | INTERVAL BE<br>ONSET AND<br>SETTING |                            |
|            | Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse lost.            | Heart 1                                   | 3-lock-co  | suplete                     |                    | 7 gr                                | ٥                          |
| CATION     | PART II. OTHER SIGNIFICANT CONDITIONS  | CONTRIBUTING TO DEATH BU                  | T NOT RELATED TO THE TERM                                    | INAL DISEASE CONDITIO       | N GIVEN IN PART    | PERFO                               | AUTOPSY<br>RMED?<br>NO [2] |
| CERTIFI    | 20a. ACCIDENT WAS UNDERLYING A 20b. DE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | SCRIBE HOW INJURY OCCURRI                 | ED. (Enter noture of injury in                               | Port I or Port II of item 1 | 8.)                |                                     |                            |
| MEDICAL    | Hour o. m. While   |   | LACE OF INJURY (Home, form octory, street, office bldg., etc | n, 20f. (City or town)      | (Cc                | ounty)                              | (Stote                     |
|            | 21. I certify that I attended the decea alive an Sept 27, 19   | -4  | 2-6, 1959, ta<br>h accurred at 10;050                        | M, fram the cause           |                    | date stated                         | dabave                     |
|            | ACTUAL SIGNATURE Moherta   | Hare                                      | M.D. 7600 C  | arroll a                    | town, stote)       | k. Park                             | re signed                  |
|            | PHYSICIAN'S Robert A   | Hare M.                                   | D. (Regularly a  | inder H.G. He               | rdley Mb           | 2) 9/                               | 27/50                      |
| 22         | g, BURIAL, CREMATION, 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OF                  | Jaskington m.  | RIGGS A H                   | YATTOVILLE         | (Stot                               | - //L                      |
| 123        | FUNERAL DIRECTOR'S SIGNATURE   | ADDRESS.                                  | 24g, REC'  | D. BY REGISTRAR 24b.        | . REGISTRAR'S SIG  | NAIUKE                              |                            |

HIARD TO BIAD THE DE DIS DEUL The first the same of the same Market 1874 and the second of SER CONTRACTOR OF STREET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs differ demay be retain by the haspital or attending physician.

TO FUNERAL D. FOR: After this certificate has been signed by the attending physician and completely filled in by the funing page 3 should be detached for use as the burial-transit permit. Then please remaye parban papers. Pages 1 and 2 should the registrar prior to burial, cremation, or remayal, and in any event within 72 haury after death.

VS A1S (4) 1SM 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CEDTICICATE OF DEATH

10350

|   | 1030   | 26                | CERTIFIC                             | AIE OF DEP  | VIII   | Reg   | . Dist. No.    |                                      |
|---|--|-------------------|--------------------------------------|---|--|---|----------------|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Montgome  | ry   |                   | MARYLAND                             | a STATE   | E (Where deceased live   | ed. If institution: Res<br>b. COUNTY<br>Montgom |                | admission)                           |
| b. CITY OR TOWN ( RURAL ond give in Fairlan                                   | (If outside corporate limited town)  (Rure                   |                   | c. LENGTH OF STAY IN 16              | c. CITY OR TOWN   | (Rural)  | limits, write RURAL                             | and give neare | ist town)                            |
| d. NAME OF HOSPI<br>OR INSTITUTION  | TAL (If not in hospitol,                                     | give street o     |                                      | d. STREET ADDRES  |  |   | - /            | IS RESIDENCE<br>ON A FARM?<br>YES NO |
| B. NAME OF<br>DECEASED<br>(Type or print)                                     | Katie  | rst               | Middle                               | Burton  | 4. DATE<br>OF<br>DEATH   | Sept.   | 4 Day          | 59 Yeor                              |
| s. sex<br>Female  | 6. COLOR OR RACE   | 7. MARRII         | DIVORCED                             | 8. DATE OF BIRTH  | 1875 "   | AGE (In yeors ost birthdoy)  Mon                |                | F UNDER 24 HR<br>Hours Min.          |
| during most of wor  | ON (Give kind of work rking life, even if retired stie       | done 10b. K       | Home                                 | DUSTRY 11. BIRTHPLACE (S                                |  | 4 7 12  | U. S.          | VHAT COUNTRY                         |
| 3. FATHER'S NAME  | eorge Jack   | son               |                                      | 14. MOTHER'S MAID                                       | DEN NAME   |   |                | 24                                   |
| (Yes, no, or unknown)   | ER IN U. S. ARMED FOR<br>Iff yes, give war ar dates of       |                   | OCIAL SECURITY NO.                   | Dora Willi  | ams Silve  | Address<br>or Spring,                           |                | Bo <b>3</b> 106<br>Route 2           |
|   | ATH [Enter only one of ATH WAS CAUSED BY: IMMEDIATE CAUSE (c | Ure               | mic Cons. I                          | pileptiferm   | and the state of t |   | ONSET          | VAL BETWEEN<br>T AND DEATH<br>CEST   |
| Conditions, if c<br>gove rise to i<br>couse (o), stoting<br>lying couse lost. | the under-   | )                 | lemiplegia (<br>rteriosclero         |   | ertension  | 1256  |                |                                      |
| Art   | thritis !  | Fibroi            | ontributing to DEATH B               | us  |  |   |                | WAS AUTOPSY<br>PERFORMED?<br>YES NO  |
| OR CONTRIBUTING   | AS UNDERLYING  G CAUSE OF DEATH MEDICAL EXAMINER)            | 206. DESCI        | RIBE HOW INJURY OCCUR                | KED. (Enter noture of injur                             | y in Port I or Part II o   | ir irem 18.)                                    |                |                                      |
| 20c. TIME OF INJUI<br>Hour o. m.<br>p. m.                                     | RY Month, Doy, Ye  | While             | JURY OCCURRED 20e. Not while of work | PLACE OF INJURY (Home,<br>foctory, street, office bldg. | , form, 20f. (City or 1  | lown)   | (County)       | (Stote                               |
|   | hat I attended the<br>Sept. 4                                | decease<br>, 1950 |                                      | 9, 19_39_, ta<br>th accurred at 12:<br>_M.D             | 15M, From the  |   |                |                                      |
| NAME (Type)   | ON. 22b. DATE THERE  |                   | 22c NAME OF CEMETERY                 | OR CREMATORY  |  | Ver-Spri<br>(City, town, or county<br>CEY U     | nty)           | (State)                              |
| 73 FUNERAL DIRECTOR   |  | Ja.               | ADDRESS PULL                         | P M 2 PATE  | RESEPTAREGISTRAR   | 24b. REGISTRAR                                  | S SIGNATURE    |                                      |

STEAR TO BEAD A TREE OF DEATH County instance was my (down) invinted and the description of a sile of A. A. A. L. Louiste Co. L. Co. at rainel (egroon) getions dress Bone , the period will market and CLEAN LAST TO ALL CLEAN CONTROL THE RESERVE AND ADDRESS OF THE PARTY OF THE and should be a change of the latest er death: Page 4

O FUNERAL D. 10R. After this certificate has been signed by the ottending physicion and campletely filled in by funeral director, page 3 should exceptached for use as the burial-transit permit. Then please remays—carbon papers. Pages 1 and 2 should be filled with the registrar priar to buriol, crematian, or remayal, and in any event within 72 fours offer death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

TO HOSPITAL OR TO FUNERAL D

VS A15 (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 48

**CERTIFICATE OF DEATH** 

| ă | 5 3 | J  | - |     |
|---|-----|----|---|-----|
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| _ |     | 9  | - | -4  |

|                | 10 | 3 |
|----------------|----|---|
|                |    | - |
| PLACE OF DEATH |    |   |

Reg. Dist. No.

| 1. PLACE OF DEATH O. COUNTY  Montgomery  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY MENTANGEN PG. |
|--|---|
| b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
| RURAL ond give neorest town) Tokoma Park   | Prince George Hyattsville /6/5/2  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   | d. STREET ADDRESS e. 15 RESIDENCE   |
| Washington Sant.   | 1100 Chillum Minor Dr   |
| 3. NAME OF DECEASED (Type or print) GRACE Middle   | CAPONE 4. DATE Month Sept. 23, 1959 19  |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.  |
| Female White WIDOWED IN DIVORCED   | Sept. 20 1887   last birthdoy)   Months Doys Hours Min.   |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   |
| Housewife  | Italy U.S.A.  |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
| James Morfesi  | ?   |
| (Yes, no. or unknown)   (If yes, give wor or dates of service)   | NFORMANT Address  |
| Aı   | ngeline Jackerson 1100 Chillum Minor D  |
| 18. CAUSE OF DEATH [Enter only one couse per line for (a) (b), and (c).]   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)   | Throwbodes 30 days  |
| 420.1 DUE TO   |   |
| Canditians, if any, which (b)  | Chilewire Hyx. Ob -   |
| gove rise to immediate cause (o), stating the under-   |   |
| lying cause lost. (c)  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?                                     |
| S ASSISTANT WAS AN ASSISTANT OF THE STATE OF | YES NO  |
| OR CONTRIBUTING CAUSE OF DEATH   | D. (Enter nature of injury in Part I or Part II of item 18.)  |
|  | ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from Cing /   | 7. 1959, to Apr 20, 1959, that I last saw the deceased  |
| alive on Agos 20, 195 9, and that death  | accurred at 2 12 PM, from the causes and an the date stated above.  |
| 1 12 1   | ADDRESS (Street, city or town, stote) DATE SIGNED   |
| SIGNATURE Andore office fareing  | MD. 915-1985 to N.W. Websl JC   |
| PHYSICIAN'S 1000 000   |   |
| NAME (Typo) IS DOYC SHULTAN  |   |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF | R CREMATORY 22d. LOCATION (City, town, or county) (Stote)   |
| Burial 9/28/59 Mt. Olivet  | Cemetery Washington D. C.   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 24a. REC'D 8Y REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| Deal Funeral Home 4812 Ga. Ave.  | Wash. DATE SEP 25'59 Cothun & House   |

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|            | er retectable for at |            |             |                  |             |
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|            |                      |            | 444 150 . T |                  | 7.71        |
|            |                      | Navi Lanas |             | BRIGHT Bone 1212 |             |

VS A1S (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397 CERTIFICATE OF DEATH

Reg. Dist. No.

10352

|   |   |           |                                    |        |  |   |   | uali nisi        | . 140.   |
|---|---|-----------|------------------------------------|--------|--|---|---|------------------|--|
| 1. PLACE OF DEATH o. COUNTY Montgome  |   |           | MARYLA                             | AND    | 2. USUAL RESIDENCE (W. STATE Maryland  | /here deceased                                  | lived. If institution becounty                      | on: Residence    | e before admission)  |
| Bethesda  |   | ts, write | c. LENGTH OF STAY IN               | 4 1b   | c. CITY OR TOWN (IF  |   |   | URAL ond gi      |  |
| d. NAME OF HOSPI<br>OR INSTITUTION  | ITAL (If not in hospital, g                               |           | chesda 14, N                       | /d.    | d. STREET ADDRESS 5117 Benni   |   |   |                  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                    |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | Fir<br>Kath   | st        | Middle Mary                        |        | Lost<br>Cappelli   | 4. DATE<br>OF                                   | Mon   | th<br>ember      | Doy Year<br>26. 19 59                                      |
| S. SEX Female   | 6. COLOR OR RACE  | 7. MARR   | IED NEVER MARRIED                  |        | DATE OF BIRTH  | 9   | . AGE (In years<br>lost birthdoy)                   | IF UNDER 1       | YEAR IF UNDER 24 HRS.<br>Doys Hours Min.                   |
| 10a. USUAL OCCUPATI   |   | lone 10b. |                                    |        | February 2, IRY 11. BIRTHPLACE (Stote  | e or foreign cou                                |   | 12. CITIZ        | ZEN OF WHAT COUNTRY  |
| 13. FATHER'S NAME   |   |           |                                    | 141    | 14. MOTHER'S MAIDEN  |   |   |                  |  |
| Joseph Ca   | appelli   |           |                                    |        | Pauline Hn   | ylanski   |   |                  |  |
| No. or unknown)   | ER IN U. S. ARMED FOR<br>(If yes, give wor or dates of st | rvice)    | None                               |        | FORMANT The Me<br>e Clinical C   |   |   |                  | Maryland   |
|   | the under-  | A         |                                    |        | estinal hemon  | rrhage  |   |                  | INTERVAL SET WEEN ONSET AND DEATH 10 min.                  |
| PART II. OT   | HER SIGNIFICANT CON                                       | neum      | onia. left                         | appe   | NOT RELATED TO THE TERM  |   |   | EN IN PART       | 1(o) 19. WAS AUTOPSY PERFORMED? YES NO                     |
|   | AS UNDERLYING  GOOD CAUSE OF DEATH MEDICAL EXAMINER)      | ZOB. DESC | RIBE HOW INJURY OCC                | URRED  | . (Enter nature of injury in   | Port I or Port I                                | f of item 18.)                                      |                  |  |
| 20c. TIME OF INJUI<br>Hour o. m.<br>p. m.   | RY Month, Doy, Yeo  | While     | JURY OCCURRED 20 Not while of work | foct   | CE OF INJURY (Home, form<br>ory, street, office bldg., etc.                  | c.)   |   |                  | ounty) (Stote)   |
| 21. I certify the alive on September 21. I certify the alive on September 21. I certify the alive on September 21. I certify the alive of the alive | tember 26 Richard C.                                      | 19.5      | retherm                            | eath • | ., 1959, to Se<br>occurred at 1:50<br>The Clinic<br>National I<br>Bethesda 1 | AM, from<br>ADDRESS (Sire<br>al Cent<br>nstitut | the causes a<br>et, city or town,<br>er<br>es of He | nd an the        | ost saw the decease e date stated abave DATE SIGNE 9-26-59 |
| 220. BURIAL, CREMATIC   | ON, 215 DATE THEREO                                       | 59        | 22c. NAME OF CEMETE                | ery or |  |   | ON (City, town, o                                   | r county)<br>Mye | (Stoje)  |
| 23. FUNERAL DIRECTOR  | 'S SIGNATURE CO.  | 517.      | ADDRESS 84                         | SE     | 24a. REC   | D BY REGISTRA                                   |   | TRAR'S SIGN      |  |

| BI GROWIT   | ALLEY AND THE ALLEY                                       |                     | T MANUEL TO  |         |
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| Ellip and or the  | CATE OF DEATH   | HINES . ST          |              |         |
| reynobl engirs  |   |                     | 12.00        |         |
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|   | other from a Right<br>and and OPLL superiments<br>current | to the same of the  | egendor 25   |         |
| Dun't Committee   | Skieni Innokoni<br>Beblenda II. 124                       | columns, M.II.      | .0 britial!! |         |
|   |   |                     |              |         |
|   | our mast  |                     |              |         |

10353 t. No.

| ) |   | director,  | ited with  | N   | 1 |   |
|---|---|--|--|---|---|---|
|   |   | me funeral   | shauld be f  |   |   |   |
|   |   | TO FUNERAL C. TOR: After this certificate has been signed by the ottending physician ond completely filled in by me funeral director | page 3 shauld be detached for use as the burial-transit permit. Then please remore coopen papers. Pages 1 and 2 shauld be fifed with |   |   | 7 |
|   |   | mpletely fi  | pers. Page   | 1.  |   |   |
|   |   | ian ond co   | cocpon pa  | after death   | / | 1 |
|   |   | ding physic  | ise remove   | n 72 haurs  |   | / |
|   |   | , the otten  | Then pled  | event with  |   |   |
|   | an.   | n signed by  | isit permit.   | the registror priar to burial, crematian, ar removal, and in any event within 72 haurs after death. |   |   |
|   | may be retain by the haspital ar attending physician. | ate has bee  | burial-trai  | removal,  |   |   |
|   | al ar attend  | his certifica  | use as the   | ematian, ar   |   |   |
|   | the haspit  | OR: After 1  | etached for  | burial, cr  |   |   |
|   | toin  | LG   | auld be d  | or priar to   |   |   |
|   | may be re   | FUNERA   | page 3 sho   | he registro   | - | ) |
|   |   | 10   |  |   | T | 9 |

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs o<u>f</u>

TO HOSPITAL OR

VS A15 (4)

15M 9/58

| 10332   | CERTIFICA                              | AIL OI DEAIL  |  | Reg. Dist. No              |   |
|---|--|---|--|----------------------------|---|
| PLACE OF DEATH a. COUNTY MONTGOMERY   | MARYLAND                               | 2. USUAL RESIDENCE (When o. STATE MARYLA                      | e deceased lived. If institution b. COUNTY | n: Residence before MONTGO |   |
| b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)                            | c. LENGTH OF STAY IN 1b                | c. CITY OR TOWN (If aut                                       | side carporate limits, write RI            | URAL and give ne           | arest tawn)                             |
| SILVER SPRING   | 14 years                               | 56 SILVER   | SPRING                                     |                            |   |
| d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION RAY DRIVE                               | address)                               | d. STREET ADDRESS<br>621 RAY                                  | DRIVE                                      |                            | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| NAME OF DECEASED (Type or print) WILLIAM  | Middle C                               | ARPENTER  | OF DEATH Sup                               | th Do                      | Year 195                                |
| SEX MALE 6. COLOR OR RACE WHITE WIDOW   | RIED A NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH<br>1/27/75                                   | 9. AGE (In years last birthday) 84 yrs.    | Manths Days                | Haurs Min.                              |
| do. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                  | KIND OF BUSINESS OR INDU               | MASS.   | fareign cauntry)                           | U.S.A                      | F WHAT COUNTRY?                         |
| CHARLES CARPENTER   |  | 14. MOTHER'S MAIDEN NA MARIAM MAR                             |  |                            |   |
| . WAS DECEASED EVER IN U. S. ARMED FORCES? (et, no, or unknown) (If yes, give war or dates of service)      |  | nformant<br>cs. Maude R. Ca                                   |  | Ray Driv                   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)          | ne for (a), (b), and (c).]             |   | Silver                                     | Spring                     | ERVAL DETWEEN SET AND DEATH 2 UK        |
| Conditions, if any, which gave rise to immediate  | Elde Vaxas                             | aler Tenel  | Disease                                    | _,                         | 0                                       |
| cause (a), stating the under-<br>lying cause last.  DUE TO (c)  | ene acts                               | uneleva   | 6  |                            |   |
| PART II. OTHER SIGNIFICANT CONDITIONS (   | CONTRIBUTING TO DEATH BUT              | THE RELATED TO THE TERMIN                                     | AL DISEASE CONDITION GIV                   | EN IN PART 1(a)            | PERFORMED? YES NO                       |
| 20a. ACCIDENT WAS UNDERLYING 20b. DESI<br>OR CONTRIBUTING 20b. DEST<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | CRIBE HOW INJURY OCCURRE               | D. (Enter nature of injury in Pa                              | rt I ar Part II af item 18.}               |                            |   |
| Hour a.m. While   | 4_                                     | ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.) | 20f. (City or town)                        | (County)                   | (State)                                 |

21. I certify that I attended the deceased fram that I last saw the deceased alive an and that death accurred at M, fram the causes and an the date stated above. ACTUAL SIGNATURE

22c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY

PHYSICIAN'S NAME (Type)

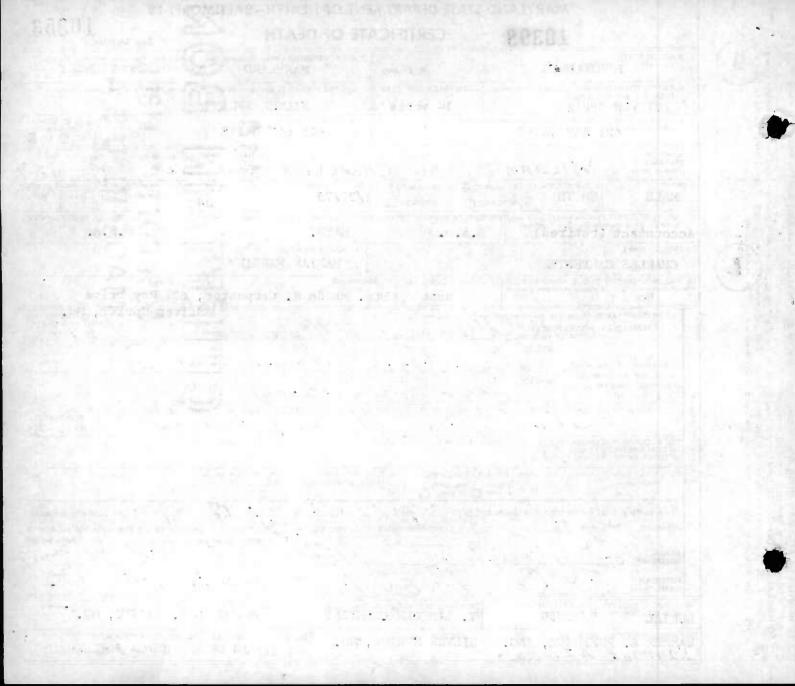
PRINCE GEO. COUNTY, MD.

SILVER SPRING, MD.

22b. DATE THEREOF

22a. BURIAL, CREMATION,

24a. REC'D 8Y REGISTRAR SEP 2 3 '59 24b. REGISTRAR'S SIGNATURE arthur & thous



TO FUNERAL D

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10354

10399 **CERTIFICATE OF DEATH** 

Reg. Dist. No.

| 1  | . PLACE OF DEATH O. COUNTY MONT GOMERY MARYLAND |   |                    | - 11                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MONT GOME FY MARYLAND |  |               |                                 |  |           |         |         |
|--|---|---|--------------------|----------------------------|--|--|---------------|---------------------------------|--|-----------|---------|---------|
|  | b. CITY OR TOWN (If<br>RURAL and give ned       | outside corporate lim<br>prest town)                                | its, write         | c. LENGTH OF STAY IN       | 116  | c. CITY OR TOWN (IF                              | outside corpo |                                 |  | ve negres | t town) |         |
| -  | OLNEY   | NEY DAY  NAME OF HOSPITAL (If not in hospital, give street address) |                    |                            | 146  | ROCKVILLE  |               |                                 |  |           |         |         |
|  | OR INSTITUTION                                  |   |                    | 1                          | d. STREET ADDRESS  |  |               |                                 |  | ON A F    |         |         |
| -  | MONTGOMERY COUNTY GENERAL HOSPITAL, INC.        |   |                    |                            | NC   | B0x 381  |               |                                 |  | Y         | ES 🔲 I  | NO 🗆    |
|  | 3. NAME OF<br>DECEASED                          | Fi  | st                 | Middle                     |  | Lost   | 4. DATE<br>OF | Mon                             | th                                     | Day       | Ye      | or      |
|  | (Type or print)                                 |   | by R               |                            |  | Carter   | DEATH         | SE                              | PTEMBE                                 | R 2       | 0 19    | 59      |
|  | 5. SEX  | 6. COLOR OR RACE  | 7. MAR             | RIED NEVER MARRIED         | K B. D.  | ATE OF BIRTH                                     |               | 9. AGE (In years lost birthday) | IF UNDER 1                             |           |         | 24 HRS. |
|  | MALE  | WHITE   | WIDOW              | ED DIVORCED                |  | /19/59   |               | yrs.                            | Months [                               | Doys 2    | ours    | M40     |
| J  | 10a. USUAL OCCUPATION                           | N (Give kind of working life, even if retired                       | done 10b.          | KIND OF BUSINESS OR        | INDUSTRY   | 11. BIRTHPLACE (Stote                            | or foreign c  | ountry)                         | 12. CITIZ                              | ZEN OF V  | VHAT C  |         |
| 1  | Infant  | ng me, even n remed   | '                  | None                       |  | MARYLAND   |               |                                 | N Ded                                  | USA       |         |         |
| ij   | 13. FATHER'S NAME                               |   |                    |                            | 14   | . MOTHER'S MAIDEN N                              | VAME          |                                 |  | 0071      |         | _       |
| 1  | CLAPE   | NCE NOLEN   | CART               | ED                         |  | HELEN  | Сыртет        | INE ROGE                        | D.C                                    |           |         |         |
| 1  | 15. WAS DECEASED EVER                           | IN U. S. ARMED FOR  | CES? 16.           |                            | 17. INFOR  |  | CHKISI        | Add                             |  |           |         |         |
|  | No (Yes, no. or unknown)                        | yes, give war or dates of s   | ervice)            | None                       | Н  | SPITAL REC                                       | 0.050         |                                 |  | Mana      |         |         |
| -  |   | na fe .   | 1                  |                            | 110  | SPITAL REC                                       | UKBS          | 0                               | LEEY,                                  | MARY      |         |         |
|  |   | H WAS CAUSED BY:  | ouse per li        | ne for (o), (b), ond (c).] | +  |  |               |                                 |  |           | AL BETY |         |
|  | A ~   | IMMEDIATE CAUSE (0) Preparaturely 24 hours                          |                    |                            |  |  |               |                                 |  |           |         |         |
|  | 1776X   | 7.76 X DUE TO   |                    |                            |  |  |               |                                 |  |           |         |         |
|  |   | Conditions, if ony, which ) (b)                                     |                    |                            |  |  |               |                                 |  |           |         |         |
|  |   | gove rise to immediate couse (a), stating the under-                |                    |                            |  |  |               |                                 |  |           |         |         |
|  | lying couse lost.                               |   |                    |                            |  |  |               |                                 |  |           |         |         |
|  | PART II. OTHE                                   |   | -                  | CONTRIBUTING TO DEAT       | H BUT NOT  | RELATED TO THE TERMI                             | INAL DISEAS   | F CONDITION GIV                 | EN IN PART                             | 1(0) 19   | WAS ALL | TOPSY   |
|  | PART II. OTHE                                   |   | 100                |                            |  |  |               | 2 00.10111011 011               | EI II II I I I I I I I I I I I I I I I | F         | PERFORM | AED?    |
|  |   | LINDERLYING T   | 20h DES            | CRIBE HOW INJURY OCC       | THORED IS  | Ass as Assa of Indian in I                       | Deat Lee Dee  | 4 11 of ia-m 1R )               |  | YI        | S 🔲 1   | 40 L    |
|  | 20a. ACCIDENT WAS<br>OR CONTRIBUTING I          | CAUSE OF DEATH  | 200. 013           | CKIDE HOW INJURY OCC       | UKKED. (EI   | ner noture of injury in i                        | ron i or rur  | i ii or iiem ib.;               |  |           |         |         |
|  |   | •   |                    |                            |  |  |               |                                 |  |           |         |         |
|  | 20c. TIME OF INJURY Hour o. m. p. m.            | Month, Doy, Ye  | or 20d. I<br>While |                            | De. PLACE ( foctory,   | OF INJURY (Home, form street, office bldg., etc. | 20f. (City    | or town)                        | (Co                                    | ounty)    |         | (Stote) |
|  | p. m.   | 19  | of wor             |                            | ,  |  |               |                                 |  |           |         |         |
|  | 21. I certify tho                               | t kattended the   | deceas             | ed from 9/19               |  | 1059 10  | 9/20          | 5 , 1959                        | that I la                              | ***       | the d   |         |
| 1  | alive an  | 1/20  | 105                |                            | looth oc   | urred at8:40 f                                   |               |                                 | ., indi i id                           | 121 20W   | me de   | sceased |
| 1  | dilve dil                                       | <i></i>   | , 125              | , and mai a                | eam occ  |  |               |                                 |  | e date    |         | abave.  |
| ACTUAL Games (Street, city or town, stote) |   |   |                    |                            |  |  | storej        |                                 | O /O                                   | SIGNED    |         |         |
|  | SIGNATURE                                       |   |                    |                            | M.D.   |  |               |                                 |  |           | 9/2     | 0/59    |
| 1  | PHYSICIAN'S                                     | 5 W   |                    |                            |  |  |               | M                               |  |           |         |         |
|  | NAME (Type) G                                   | . F. MEADO  |                    | Ч. D.                      |  |  | UAMAS         | CUS, MAR                        | YLAND                                  |           |         |         |
| 1  | 220. BURIAL, CREMATION -REMOVAL (Specify)       | , 22b. DATE THEREC  | F                  | 22c. NAME OF CEMET         | ERY OR CRI   | MATORY   | 22d. LOCA     | TION (City, town, o             | or county)                             |           | (Stote) |         |
|  | BURIAL  | 15xp1.23  | 1959               | PARNESTO                   | MN F   | RESLY CEM  | DAI           | RNESTOI                         | WN,                                    | M         | 0       |         |
| 2  | 3. PUNERAL DIRECTOR'S                           | SIGNATURE   | ,                  | ADDRESS                    |  | 240. REC"  | D BY REGIST   | RAR 24b. REGIS                  | TRAR'S SIGN                            | NATURE    |         |         |
|  | Notest (  | 1. June   | olus.              | 1307                       | kest   | DE SOATE SE                                      | P 2 4 '5      | 9 Cn                            | Thun & 3                               | Trans     |         |         |
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| nin 24 naurs of dearn. rage 4 | led in by the funeral director, | ages I and 2 shauld be filed with |   | 人一個一 |  |
|                               | 14                              | ge                                |   |      |  |

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with may be even by the haspital at attending physician.

D FUNDAL DIA JOR: After this certificate has been signed by the attending physician and completely page 3 shauld be detached far use as the burial-transit permit. Then please remave carbo pages the registrar priar to burial, crematian, at remaval, and in any event within 72 haurs after death.

AN HOSPITAL ON NO. 12 W 9/2B

|               |  | 10400  | CERTII                          | FICA     | ATE OF D             | EATH                     | •                                  | Reg. Dist.    | No.         |                   |
|---------------|--|--|---------------------------------|----------|----------------------|--------------------------|------------------------------------|---------------|-------------|-------------------|
|               | PLACE OF DEATH a. COUNTY                 | NTGOMERY   | MARYL                           | AND      | o. STATE             | PENCE (Where deceased    | h COUNTY                           | on: Residence |             |                   |
|               | b. CITY OR TOWN (If                      | autside carporate limits, wr                                 | te c. LENGTH OF STAY I          | N 16     |                      | OWN (If outside corpo    |                                    |               |             |                   |
|               | RURAL ond give ned                       | SPRING.  | 174EM                           | +RS      | 56 sic               | VER SP                   | RING.                              |               |             |                   |
|               | d. NAME OF HOSPITA<br>OR INSTITUTION     | L (If not in hospital, give st                               |                                 |          | d. STREET A          |                          | TREG                               | 1156          | e. IS RES   | FARM?             |
| _             | 8310                                     |  |                                 |          |                      | 1                        |                                    |               | YES L       | NO []             |
| 3.            | NAME OF<br>DECEASED<br>(Type or print)   | First  | Middle ESTEL                    | Ce       | lool<br>(ASA)        | OF                       | SEP7                               |               | -           | Year<br>19 5 9    |
| 5.            | SEX                                      | 6. COLOR OR RACE 7. A  | ARRIED NEVER MARRIE             |          | B. DATE OF BIRTH     | 0 = 1                    | 9. AGE (In years<br>lost birthdoy) |               | YEAR IF UND | _                 |
|               | FEMALE                                   | WHITE WID  | OWED DIVORCED                   |          | DEC. 2               | 0,1811                   | 87 yrs.                            | Monns         | oys Hours   | Min.              |
| 100           | during mast of warking                   | N (Give kind of work dane ng life, even if retired)  (retire | 10b. KIND OF BUSINESS OF        | INDUS    | TRY 11. BIRTHPL      | ACE (State or foreign of |                                    |               | NOF WHAT    | COUNTRY?          |
| 13.           | FATHER'S NAME                            |  |                                 |          | 14. MOTHER'S         | MAIDEN NAME              |                                    |               |             |                   |
|               | GE                                       | ORGE M.  | CECII                           |          |                      | SARAH                    | J. RO                              | FK KE         |             |                   |
| 15.           | WAS DECEASED EVER                        | IN U. S. ARMED FORCES?                                       | 16. SOCIAL SECURITY NO.         | 11       | NFORMANT             | 9/18/80                  | Add                                | ress          |             | 5 - F             |
| (10           | is, no, or unknown)                      | yes, give war or dates of service)                           | NONE                            | MI       | ARY LET              | E CASHELC                | . A5                               | ABOV          | 6.          |                   |
| _             | 18. CAUSE OF DEAT                        | H [Enter only ane cause p                                    | er line for (a), (b), and (c).] |          |                      |                          |                                    |               | INTERVAL BE | TWEEN             |
|               | PART I. DEAT                             | H WAS CAUSED BY:   | CEREB                           | RA       | 1 TH                 | ROMBOSIS                 |                                    | 1             | ONSET AND   |                   |
|               | 332×                                     | DUE TO   |                                 |          |                      |                          |                                    |               |             |                   |
|               | Canditians, if on                        | y, which ) (b)   | CERERA                          | 2A1      | ATH                  | EROSCLET                 | 20.5/2                             |               | 2 4FA       | RO                |
|               | gave rise to im<br>couse (a), stoting th | mediote (  |                                 |          |                      |                          | 0 /                                | 100           | -           |                   |
|               | lying cause last.                        | (c)  |                                 |          | 0.76                 | d Elicent                | Section 19                         |               |             |                   |
| CERTIFICATION | PART II. OTHE                            | R SIGNIFICANT CONDITIO                                       | NS CONTRIBUTING TO DEA          |          | NOT RELATED TO       |                          | E CONDITION GIV                    | EN IN PART 1  | PERFC       | AUTOPSY<br>ORMED? |
| TFIC          | 20a. ACCIDENT WAS                        | UNDERLYING 20b.  | DESCRIBE HOW INJURY OF          |          |                      |                          | t II af item 18.)                  |               |             |                   |
| CERI          | OR CONTRIBUTING (                        | CAUSE OF DEATH   |                                 |          |                      | The con-                 |                                    |               |             |                   |
|               | 20c. TIME OF INJURY                      | Month, Doy, Year 20  | d. INJURY OCCURRED              |          | ACE OF INJURY (      |                          | or town)                           | (Car          | unty)       | (State)           |
| MEDICAL       | Hour o.m.                                |  | hile Not while work at work     | foc      | tory, street, office | bldg., etc.)             |                                    |               |             |                   |
| 2             |  |  | eased fram. SEP7                | - 9      | 10.52                | . SEPT 3                 | 7 1056                             |               | Al.         |                   |
|               | alive anSE                               |  | 9.59 , and that                 |          |                      |                          |                                    |               |             |                   |
|               | dive on                                  | K-1, 1   | y, and that                     | aearn    | accurred at          |                          | reet, city or town,                |               |             | a abave.          |
|               | ACTUAL                                   | Vamosa.  | Relate                          | ٩.       | M.D. 890             |                          |                                    | SNUE          | C'4 P7      | -3 10x            |
|               | SIGNATURE                                | jumpeu.  | TO THECK S                      | /        | M.D                  | Y                        | Zt                                 | ~ 1 4 0 CJ    | -36/1       | L                 |
|               | PHYSICIAN'S<br>NAME (Type)               | JAMES A  | , ROBERTS                       |          |                      | SILVE                    | R SPI                              | RING,         | MI          | )                 |
| 22            | BURIAL, CREMATION                        | , 22b. DATE THEREOF  | 22c. NAME OF CEME               | TERY OI  | R CREMATORY          |                          | TION (City, town,                  |               | (Sto        | te)               |
|               | BURIAL (Specify)                         | 9/7/59   | ROCKVILLE                       |          |                      | MONTG                    | OMERY CO                           | UNTY, 1       | MARYLA      | D                 |
| 23.           | FUNERAL DIRECTOR'S                       | SIGNATURE INC  | STLVER SP                       | RINC     | , MD.                | 24a. REC'D BY REGIST     |                                    | STRAR'S SIGN  | IATURE      |                   |
|               | Raymond                                  |  | . OTHARK OF                     | r. T 140 | , ElD.               | DATE SEP 8 'S            | 59 a                               | ithur & 1     | Traus       |                   |

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| 5   | TO FUNERAL<br>or removal.   |
| TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is recessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded it would be a relative to the formal property of the formal property of the property of the formal property of the | TO FUNERAL DESCROR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 with the registrar prival to burial, cremotian, or remand. |

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| s certificate shauld be executed within 24 haurs after death. If any delay is necessary, please exe | "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 shauld by | siner's Office along with farm PM3. Page 5 may be retained for your files. | os o pr   |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| Reg. |       | 1   | 0 | 3 | 5 | 6 |
|------|-------|-----|---|---|---|---|
| Reg. | Dist. | No. | U | U | U | U |

| O. COUNTY                                  | 70301                                  |                               | 2. USUAL RESIDENCE (Where            |                                       | Residence before admission)          |
|--|--|-------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|
| h  | April, maser.                          | MARYLAND                      | o. STATE had                         | b. COUNTY                             | 1 am to                              |
| b. CITY OR TOWN III                        | outside corposole limits, write RURAL  | c. LENGTH OF STAY IN 16       | C. CITY OR TOWN (If outsig           | de corporate limits, write RURA       | L and give negrest lawn)             |
| and give nearest town                      |  | 0                             | 1 00                                 |                                       |                                      |
| 134  | Thedda                                 | Hew Terers                    | > Cherry                             | Charl                                 |                                      |
| d. NAME OF HOSPIT                          | AL OR INSTITUTION (If not in I         | nospital give street address) | d. STREET ADDRESS                    |                                       | e. IS RESIDENCE<br>ON A FARM?        |
| 8009                                       | Kenthen                                | A                             | 1 27061 1                            | nous Rl                               | YES NO NO                            |
|  | 1 marring                              |                               | 3/07/                                | Harry 114                             |                                      |
| 3. NAME OF<br>DECEASED                     | / Fint                                 | ) Middle                      | Last 4. D                            | ATE Month                             | Day Year                             |
| (Type or print)                            | Lahous                                 | To restorbly Ch               | ah1.400 DI                           | ATH /46h                              | 14 1959                              |
| S. SEX                                     | 6. COLOR OR RACE 7- MAR                | RRIED NEVER MARRIED 8.        | DATE OF BIRTH                        | 9. AGE (In years IF U)                | NDER TYEAR IF UNDER 24 HRS.          |
| 100 - 0                                    | 0 1                                    |                               | 11 110 16                            | last birthday) Mon                    | the Days Hours Min.                  |
| male                                       | ithite WIDOV                           |                               | 11-15-190                            | yrs.                                  |                                      |
| 100. USUAL OCCUPATION                      | ON (Give kind of work done 10b         | . KIND OF BUSINESS OR INDUSTI | Y 11. BIRTHPLACE (Stole or for       | eign country) 12                      | . CITIZEN OF WHAT COUNTRY?           |
| during most di workin                      | g life, even if ratired)               | o the second                  | CP                                   |                                       | 11 8 6                               |
| 12 547115015 24445                         | 17-                                    | 24 Houng                      | 316-                                 |                                       | 101-30                               |
| 13. FATHER'S NAME                          |  |                               | 14. MOTHER'S MAIDEN NAME             |                                       |                                      |
| ha for                                     | C. Chapk                               | 100                           | Marker Com                           | montere                               | Z                                    |
| 15. WAS DECEASED EV                        | ER IN U. S. ARMED FORGES 1             | 6. SOCIAL SECURITY NO. 17. IN | FORMANT                              | Address                               |                                      |
| (Yes, no, or unknown)                      | (If yes, give war or dates of service) | m                             | 1 10 00 100                          | 0/-                                   | 7                                    |
| 710  |  | Thank Is                      | atell Chappie                        | ep - sien                             | <u></u>                              |
| 18. CAUSE OF DEA                           | TH [Enter only one cause per lin       | ne for (o), (b), and (c).]    | //                                   |                                       | INTERVAL BETWEEN<br>ONSET AND DEATH  |
| PART I. DEA                                | TH WAS CAUSED BY:                      | Godd.                         |                                      |                                       | Order And Bearing                    |
| Dry  | IMMEDIATE CAUSE (a)                    |                               |                                      |                                       |                                      |
| 7/4×                                       | DUE TO                                 | H / *                         |                                      | ,                                     |                                      |
| Conditions, if o                           |  | Rayper                        |                                      |                                       |                                      |
| gove rise to imme                          |  | - Good                        |                                      |                                       |                                      |
| (o), sloting the                           | underlying                             |                               |                                      |                                       |                                      |
|  | ) (c)                                  |                               |                                      |                                       |                                      |
| PART II. OTH                               | ER SIGNIFICANT CONDITIONS              | CONTRIBUTING TO DEATH BUT N   | OT RELATED TO THE TERMINALD          | ISEASE CONDITION GIVEN IN             | PART 1(0) 19. WAS AUTOPSY PERFORMED? |
| ¥.   |  |                               |                                      |                                       | YES NO NO                            |
| PART II. OTH                               | ISE WAS 206 DESCI                      | RIBE HOW INJURY OCCURRED. (E  | pler nature of injury in Port I or i | Port II of item 18 \                  |                                      |
| PRIMARY Or CO                              | NTRIBUTING Y                           | A / A                         | ***                                  | - Marie 10.7                          |                                      |
|  | then                                   | g self Mn                     | ech in sis                           | lus home                              |                                      |
| 20c. TIME OF INJU                          | RY Month, Day, Year 20g                | INJURY OCCURRED 200. PLAC     | E OF INJURY (Home, form, 20)         | . (City or town)                      | (County) (State)                     |
| Hour o. m.                                 |  | INIO IAOI MITIIO              | ry, street, office bldg., etc.)      | 0 30                                  | we h m.l                             |
|  |  | work at work                  | home!                                | Dernedy                               | money my                             |
| 21. I certify the                          | nat I took charge of the               | e remains described above     | re, held an Autopsy                  | , Inspection X, In                    | quiry . and find that                |
| death resulted                             | from: Natural causes                   | Accident . Suice              | ide , Homicide .                     | Undetermined cause                    | П.                                   |
|  |  |                               | - <b>(24)</b>                        |                                       |                                      |
| ACTUAL                                     | 1 . 1 2                                |                               | Professional Control                 |                                       | DATE SIGNED                          |
| SIGNATURE_                                 | 2aul 1.19                              | perheut                       | _M.D. CHIEF MEDICAL EXAMIN           | ER 🔲                                  |                                      |
|  | - 1                                    |                               | ASSISTANT MEDICAL EXA                | AMINER 🗍                              | 1.                                   |
| EXAMINER'S<br>NAME (Type)                  | FLARW TR                               | roschzit                      | DEPUTY MEDICAL EXAMI                 | NER DA                                | 14-59                                |
|  | 1 17 PM 0.13                           |                               |                                      | , , , , , , , , , , , , , , , , , , , |                                      |
| 22a. BURIAL, CREMATIC<br>REMOVAL (Specify) | ON, 22b. DATE THEREOF                  | 22c. NAME OF CEMETERY OR      | CREMATORY 22d.                       | LOCATION (City, town, or cou          | inty) (Stote)                        |
| Burial                                     | 0/17/50                                | Parklawn Cer                  | netery I                             | Rockville, M                          | arvland                              |
| 23. FUNERAL DIRECTOR                       |  | ADDRESS                       | 24o. REC'D BY I                      |                                       |                                      |
|  |  |                               |                                      |                                       | S. Kraus                             |
| Robert                                     | A. Pumphrey                            | Bethesda, Ma                  | ryland DATE OFF                      | COXM                                  | 23. 100000                           |
|  |  |                               | M                                    |                                       |                                      |

MEDICAL EXAMINARYS CORTUGARE OF DEATH The security of the section was Education St. Comp. 13 s. THE RESIDENCE OF THE PARTY OF T Constitution and the confidence of appeal of the contract of t CATALON AND AND ADDRESS OF THE PARTY. District Control of the Control of t CALLERY CONTRACTOR ASSESSMENT CONTRACTOR A STANIS

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10357 Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Penn South Hall Hall c. CITY OR TOWN (If outside carporate limits, write PULAL and give nearest town) Paol1 201176 e. IS RESIDENCE ON A FARM? 并在本年会市及共产民 YES NO T Month Day Year 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. yrs. 12. CITIZENLOF WHAT COUNTRY? Address INTERVAL BETWEEN ONSET AND DEATH 20h PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO IN (County) (State) Ithat I last saw the deceased M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 22d. LOCATION (City, town, or county) (State) Penn. 24b. REGISTRAR'S SIGNATURE arthur & thous DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 CERTIFICATE OF DEATH

| 10707  | CERTITICA  | AL OF BEATT  | Reg. Dist. No. 215   |
|--|--|--|--|
| 1. PLACE OF DEATH A COUNTY MONTGOMERY  | MARYLAND   | 2. USUAL RESIDENCE (Where deceo  | sed lived. If institution: Residence before admission) b. COUNTY   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give neares town) Bethesda (Rural)   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY   VITE 11a   | porote limits, write RURAL and give nearest town)  |
| d. NAME OF HOSPITAL (If not in hospital, give stre   |  |  |  |
| U. S. Naval Hospita.   |  | C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  |
| 3. NAME OF First   | Middle   | Last 4. DATE   | Month Day Year   |
| (Type or print) Emory  | Fitch  | CLEMENT DEAT   | TABLE CONTROLLED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  TITCH TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(b)  TITCH TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(b)  TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)  TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d)  TO THE TERMINAL DIS |
| 5. SEX 6. COLOR OR RACE 7. MA  | ARRIED NEVER MARRIED   | B. DATE OF BIRTH   |  |
| Male Caucasian willoo  | WED DIVORCED   | 11-17-87   | 7-1  |
| 10a. USUAL OCCUPATION (Give kind of work dane 10<br>during most of working life, even if retired)  | b. KIND OF BUSINESS OR INDU  | STRY 11. BIRTHPLACE (State or foreign  | country) 12. CITIZEN OF WHAT COUNTRY?  |
| Mariner  | J.S.Navy   | AMARYLAND   2. USUAL RESIDENCE (Where decessed lived. If institution: Residence before admission)   D. COUNTY      |  |
| 13. FATHER'S NAME  |  | ABPT   CLEMENT   SATE   September   SEPTEMBER   SATE   SEPTEMBER   SATE   SEPTEMBER   SATE   SEPTEMBER   SATE    |  |
| Maynard CLEMENT  |  | 2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission) b. COUNTY b. COUNTY b. COUNTY b. COUNTY b. COUNTY b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond d. STREET ADDRESS 4.500 Dunston Ave.  14. DATE CLEMENT DEATH September 9. AGE (In years light birthday) DATE CLEMENT DEATH September 9. AGE (In years light birthday) DOY NOW 11. BIRTHPLACE (State or foreign country) NEW YORK 11. BIRTHPLACE (State or foreign country) NEW YORK 14. MOTHER'S MAIDEN NAME CLARA FITCH RHORMANT HOSPITAL RECORDS  NIC CARC (NOIM A ENTITED TO NOSETAND DEATH ONSETAND DEATH CARC (NOIM A ENTITED TO STATE OF MICHIELD TO ST |  |
| 15. WAS DECEASEDEVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  Yes  WI & II  |  |  |  |
| PATTER IOSC LERGT C  20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  OR CONTRIBUTING  (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Doy, Year  Hour a. m. p. m.  19  OR CONTRIBUTION  ON THE OF INJURY Manth, Doy, Year  ON THE OF INJURY MANTH  ON THE OF INJURY M | IS CONTRIBUTING TO DEATH BUT  HEART DISEAS  DESCRIBE HOW INJURY OCCURRED  I. INJURY OCCURRED  The state of th | NOT RELATED TO THE TERMINAL DISE.  D. (Enter noture of injury in Port I or P  ACE OF INJURY (Home, form, 20f. (C) tory, street, affice bldg., etc.)  | ASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?  YES NO  art II of item 18.)  (County) (State)  |
| 21. I certify that I attended the dece alive an Sept. 8 , 19  ACTUAL SIGNATURE PHYSICIAN'S F. S. CALDWEI   | 259, and that death  | accurred at 7:00 AM from ADDRESS M.D. U.S. Nava  | n the causes and an the date stated abave. (Street, city or town, state)  DATE SIGNED  11 Hospital 9-9-59  |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF  | 22c. NAME OF CEMETERY O  | R CREMATORY 22d. LOC   | ATION (City, town, or county) (Stote)  |
| Gremation 9-10-59  | Cedar Hill   |  |  |
| R. A. Pumphrey Funeral   | Home, Bethes   |  | 150  |

PLACE OF DEATH o. COUNTY

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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MARYLAND

|   | TE OF DEATH   | Reg. Dist. No.  |
|---|---|---|
|   | 2. USUAL RESIDENCE (Where deceased lived. o. STATE Maryland | If institution: Residence before admission) COUNTY Montgomery |
|   | c. CITY OR TOWN (If outside corporate lim                   | its, write RURAL and give nearest town)                       |
|   | 56 Silver Spring,   |   |
| t |   |   |

Montgomery b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 RURAL and give nearest town) Silver Spring Months d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS IS RESIDENCE ON A FARM? LeDeau Gardens Nursing Home Selfridge YES NOT NAME OF DECEASED 4. DATE Middle Lost Month Day Year (Type or print) Maggie September Dora Clore DEATH 6 19 6. COLOR OR RACE 7. MARRIED TONEVER MARRIED 9. AGE (In years lost birthday) IF UNDER I YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH Female Caucasia WIDOWED [ DIVORCED T NE 10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if belired) 12. CITIZEN OF WHAT COUNTRY? OUSE Wi 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Sameas 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Pulmonary Congestion days DUE TO Carcinoma, Lung, Right Conditions, if any, which gave rise to immediate DUE TO couse (o), stoting the underlying couse lost. Brenchopneumonia days CATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NOW XX 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stote) Hour o. ft. foctory, street, office bldg., etc.) Not while ot work ot work p. m. June 21. I certify that I attended the deceased from Sep 1952, that I last saw the deceased and that death occurred at MPfram the causes and on the date stated above. ADDRESS (Streel, city or town, state) ACTUAL SIGNATURE 10609 Concord Street

Thibadeau. M.D. Robert Kensington, Maryland NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOGATION (City, town, or county)

(State) DREMOVAL (Specify) (red. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

PHYSICIAN'S

W. W. CHAMBERS CO. 1400 Chapin St. N

24g, REC'D BY REGISTRAR SEP 1 8 '59 24b. REGISTRAR'S SIGNATURE Cirilwa & Fraus

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# MARYLAND STATEDEPARTMENT OF HEALTH-EALTHMORE TO

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10362

Reg. Dist. No.

| 1. PLACE OF DEATH Montgomery   | MARYLANI                           | 2. USUAL RESIDENCE (Where deceased lived. If Institution of STATE NewYork b. COUNTY  |   |
|--|------------------------------------|--|---|
| b. CITY OR TOWN (If outside corporate limits, write and give negrent fown) Bethesda            | c. LENGTH OF STAY IN 16            | c. CITY OR TOWN (If outside corporate limits, write in the control of the control |   |
| d. NAME OF HOSPITAL OR INSTITUTION ( Suburban Hospit   |                                    | d. STREET ADDRESS  19 Abbey Lane   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO T               |
| 3. NAME OF DECEASED (Type or print) Lucy   | _                                  | Lost 4. DATE Month OF DEATH Sept 20  | Doy Year<br>, 1959 19                                   |
| female 6. COLOR OR RACE white  | WIDOWED DIVORCED                   | April n1921 38 yrs.  | IF UNDER 14EAR IF UNDER 24 HRS.  Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)         | done 10b. KIND OF BUSINESS OR INDU | 11. BIRTHPLACE (State or foreign country)  | 12. CITIZEN OF WHAT COUNTRY? USA                        |
| 13. FATHER'S NAME John Sudduth   |                                    | 14. MOTHER'S MAIDEN NAME Lena Jones  | W.,   |
| 15. WAS DECEASED EVER IN U. S. ARMED FO<br>(Yes, no, or unknown) (If yes, give wor or dotes of | pervice)                           | INFORMANT Address Lice P. Bean, 7019 Ga. Ave.,   | Silver Spring Md.                                       |
| 18. CAUSE OF DEATH [Enter only one can<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o   | Evanguingtion                      |  | interval between onset and death 32 hours               |
| Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying couse lost. | Ruptured Spleen                    | nt   | 3½ hours  |
| PART II. OTHER SIGNIFICANT CON   | NDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVE   | N IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO        |
|  | Auto accident                      | (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Ye 12 . H20 o.m. 9/20/59                                       |                                    | ACE OF INJURY (Home, form, 20f. (City or town) tory, street, office bldg., etc.)  highway Bethesda   | (County) (State) Montg. , Md.                           |
| 21. I certify that I took charge death resulted from: Natural                                  |                                    | ove, held on Autopsy . Inspection ., icide ., Undetermined co  | Inquiry _, and find that guse                           |
| ACTUAL SIGNATURE  EXAMINER'S NAME (Type)  Fronk T  | Broschert                          | M.D. CHIEF MEDICAL EXAMINER ☐  ASSISTANT MEDICAL EXAMINER ☐  DEPUTY MEDICAL EXAMINER ☑   | DATE SIGNED   |
| 220. BURIAL, CREMATION, REMOVAL (Specify) Buyral (Specify)                                     |                                    | 90   | o (20/59 r county) (Stole) L. Long Island, N. J.        |
| 23. FUNERAL DIRECTOR'S SIGNATURE  H. Don , DE JOL 3  |                                    | Wash, 240. REC'D BY REGISTRAR 246. REGIST  | TRAN'S SIGNATURE  |

PERSONAL REPORT OF THE PROPERTY OF THE PROPERT Clim take kenun kiel ... Urzali nabienakiek hari A TOTAL OF BUILDINGS AND ASSESSMENT OF BUILDINGS maintain transfer and the contract of the cont Bases to the first I to the line of the second to the seco

deoth. Page 4.

| 1 | MARYLAND ST | ATE DEPARTMENT | OF HEALTH—BALTIMORE | , 18 |
|---|-------------|----------------|---------------------|------|
| * | 10/00       | CERTIFICATE    | OF DEATH            |      |

CERTIFICATE OF DEATH

10363

|  | 10   | 400                             |                        |                   |  |               |   | Keg. L                | JIST. NO  |            |                   |
|--|--|---------------------------------|------------------------|-------------------|--|---------------|---|-----------------------|-----------|------------|-------------------|
| 1. PLACE OF DEATH o. COUNTY M(   | ONTGOMERY  |                                 | MARYLAN                |                   | USUAL RESIDENCE (WHO STATE VIRGI                   |               | d lived, If instituti<br>b. COUNTY      |                       | ence befo | re odmissi | ion)              |
|  |  | ts, write                       | c. LENGTH OF STAY IN 1 | Ь                 | c. CITY OR TOWN (IF COLON)                         | outside corpo |   | RURAL one             | give ned  | arest town | )                 |
| D. COUNTY  MONTGOMERY  b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  OLINEY  d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTIONMONTGOMERY COUNTY GENERAL  3. NAME OF DECEASED (Type or print)  5. SEX  MALE  WHITE  MIDOWED  To  WIDOWED  100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired)  13. FATHER'S NAME  JONATHAN CREIGHTON  15. WAS DECEASEDEVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  16. SOCIAL SECURITY NO.  17. MARRIED  NO  18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)  DUE TO  Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH IN CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  19. OR CONTRIBUTING OF INJURY Month, Doy, Year Hour o. m.  p. m.  19. OH DESCRIBE HOW INJURY OCCURRED While Not while of work of the w | 1  | d. STREET ADDRESS<br>48 Roanoke | -                      |                   | 00   |               |   | IDENCE<br>FARM?<br>NO |           |            |                   |
|  |  | Lost<br>CGHTON                  | 4. DATE<br>OF<br>DEATH | Mor<br>SEP        | TEMBI  | ER 18         | ,                                       | Yeor<br>1959          |           |            |                   |
|  |  |                                 |                        | 8. D.<br>9/       | 15/81  |               | 9. AGE (In years lost birthdoy) 78 yrs. | Months                |           | Hours      | R 24 HRS.<br>Min. |
| 10o. USUAL OCCUPATION during most of wor   | king life, even if retired                             | )                               | KIND OF BUSINESS OR IN | IDUSTRY           | 11. BIRTHPLACE (Stote Liverpoo                     |               |   | 12.CI                 |           | J.S.A      | OUNTRY            |
| 13. FATHER'S NAME  |  |                                 |                        | 14                | I. MOTHER'S MAIDEN                                 | NAME          |   |                       |           |            |                   |
| JONATHAI   | N CREIGHTON  | -                               |                        |                   | Sarah  | ur            | known                                   |                       |           |            |                   |
| (Yes, no, or unknown)  |  |                                 |                        | Mrs.              | W. L. Do   | uglas         | Olney,                                  |                       | land      |            |                   |
| gove rise to i<br>couse (o), stoting<br>lying couse lost.  | my, which the under-                                   | )                               | ONTRIBUTING TO DEATH   | 8UT NOT           | RELATED TO THE TERM                                | INAL DISEAS   | SE CONDITION GIV                        | VEN IN PA             |           | PERFO      | AUTOPSY<br>RMED?  |
|  | AS UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC                       | RIBE HOW HUNRY OCCU    | RRED. (E          | nter noture of injury in                           | Port I or Por | rt II of item 18.)                      |                       |           |            |                   |
| Y 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.  |  | While                           | Not while              | PLACE<br>foctory, | OF INJURY (Home, form<br>street, office bldg., etc | n, 20f. (City | y or town)                              |                       | (County)  |            | (Stote)           |
| 21. I certify th   | at I attended the                                      | decease                         | ed from 8-5            | 5                 | , 1954, to   | 9-1           | £ 1917                                  | that I                | last sav  | v the d    | eceased           |
| ACTUAL   | -18<br>Decy Bo   | Per                             | 7, and that dec        | ath ac            | 21116  | M, fram       |   | nd on th              |           | stated     |                   |
| NAME (Type)  | Koy B  | Pa                              | rsons U.               | <u>r</u>          | Riv  | 2,0           | Looke                                   | M                     | of        | ()         |                   |
| TRANSAL (Specify)  | URIAL 9/18   |                                 | 22c. NAME OF CEMETER   | Y OR CR           | EMATORY  |               | TION (City, town, nial Hei              |                       |           | (Stote     | e)                |
| 23. EUNERAL DIRECTOR   | A Co   | INC.                            |                        | PRINC             | G, MD 24a. REC                                     | SEP 21        |   | ISTRAR'S              |           |            |                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs VS A1S (4) 1SM 9/S8

pungwa saluman ned Evaluation and Assert 7 . . . . hand the footbase, Sincy, Postand

VS A15 (4) 1SM 9/5B

10364

e. IS RESIDENCE

Hours

INTERVAL BETWEEN ONSET AND DEATH

L weeke

PERFORMED? YES NO

(Stote)

DATE SIGNED

(Stote)

12. CITIZEN OF WHAT COUNTRY?

ON A FARM?

YES NO

Year

1959

Reg. Dist. No

Doys

U. S. A.

(County)

Calling & Kans

| ,         | Links                              | Mossecim       |                           | 77. 3 50° 5 ° 10° |           |
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|           |                                    | Rottentur      | 116 days                  |                   | 139119    |
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| ?         | esterier 3                         | i ji i wak     | (mon) I                   | 91614             |           |
|           | Q2 00                              | Porember 9, 18 | The last                  | 80 id             | 5.[04     |
| ,A .      | i u E                              | ing legi       | explose from the All      | a.                | Cretofile |
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| Barrer 14 | E Communication                    | all sules      | how personal              |                   |           |
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|           | SATE A FORM                        |                | NO BELLEVIOLET CONTRACTOR |                   | CHICK     |

VS A1S (4) 1SM 9/S8



10365

| 104  | 18 CERTIFIC.                       | AIE OF DEATH  | Reg.  | Dist. No. 215                                 |
|--|------------------------------------|---|---|---|
| PLACE OF DEATH  o. COUNTY  Montgomery  | MARYLAND                           | 2. USUAL RESIDENCE (When a. STATE Maryland                      | re deceosed lived. If institution: Resi<br>b. COUNTY  | dence before admission)                       |
| b. CITY OR TOWN (If outside corporate limit RURAL and give nearest tawn)                         | ts, write c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If aut   | tside corporate limits, write RURAL or                | nd give nearest town)                         |
| Bethesda (Rural) d. NAME OF HOSPITAL (IF not in hospitol, gi OR INSTITUTION                      | 82 days                            | Chevy Chas  | e   | e. IS RESIDENCE<br>ON A FARM?                 |
|  | al, Bethesda Md.                   | 3902 Aspen  | Street  | YES NO NO                                     |
| B. NAME OF DECEASED (Type or print) Clara  |                                    | RITCHFIELD (  | 4. DATE Manth OF DEATH September                      | Day Year 1959                                 |
| S. SEX 6. COLOR OR RACE  | 7. MARRIED NEVER MARRIED           | B. DATE OF BIRTH  | 9. AGE (In years IF UNI                               | DER 1 YEAR IF UNDER 24 HRS.                   |
| Female White   | WIDOWED DIVORCED                   | 8-1-86  | lost birthdoy) Month                                  | hs Doys Hours Min.                            |
| Oa. USUAL OCCUPATION (Give kind af work d<br>during most of working life, even if retired)       | done 10b. KIND OF BUSINESS OR INDU | JSTRY 11. BIRTHPLACE (State or                                  | fareign country) 12.0                                 | CITIZEN OF WHAT COUNTRY?                      |
| Housewife  | None                               | Ohio  |   | U.S.  |
| 3. FATHER'S NAME   |                                    | 14. MOTHER'S MAIDEN NA  | ME  |   |
| George PRINCE  |                                    | Maryette  | SPURGEON  |   |
| S. WAS DECEASED EVER IN U. S. ARMED FORG<br>(Yes, no, or unknown)                                | ervice)                            | INFORMANT   | Address   |   |
| No   | 577 01 6081 (                      | Daughter) Ru  | th C. REID San  | ne as #2                                      |
| 18. CAUSE OF DEATH [Enter only one cou<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)    | 1 vim Ohrear                       | COMA-   |   | ONSET AND DEATH                               |
| DUE TO   | 7.17.110.5/118                     | · · · · · · · · · · · · · · · · · · ·                           |   | 10 11100                                      |
| Conditions, if any, which ) (b)  |                                    |   |   |   |
| gave rise to immediate cause (o), stating the under-   |                                    |   |   |   |
| , (0)  | DITIONS CONTRIBUTING TO DEATH BU   | T NOT RELATED TO THE TERMIN.                                    | al disease condition given in I                       | PART 1(o) 19. WAS AUTOPSY PERFORMED? YES X NO |
| 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRI   | ED. (Enter noture of injury in Po                               | rt I or Part II of item 18.)                          |   |
| 20c. TIME OF INJURY Month, Day, Yea<br>Hour o. m.  | While Not while fo                 | LACE OF INJURY (Home, farm, octory, street, office bldg., etc.) | 20f. (City or town)                                   | (County) (Stote)                              |
| ≥ p. m.  | ot work ot work                    | EO 0/1  | Comb EO   |   |
| 21. I certify that I attended the alive an 24 September  |                                    |   | A, fram the causes and an                             |   |
| ACTUAL SIGNATURE C. 49. VI   | nuth                               | M.D. U.S. Nava  | DDRESS (Street, city or town, stote)  1 Hospital, Bet | the sda, Md.                                  |
| PHYSICIAN'S R.G. MUTH  | LT MC USN                          | U.S. Nava   | l Hospital, Bet                                       | hesda, Md.                                    |
| 220. BURIAL, CREMATION, 22b. DATE THEREO<br>REMOYAL (Specify)                                    | F 22c. NAME OF CEMETERY C          | OR CREMATORY 2  | 2d. LOCATION (City, town, or count                    | ty) (State)                                   |
| Burial   9-30-59   |                                    | etery   | Big Prairie   | Ohio  |
| 3. FUNERAL DIRECTOR'S SIGNATURE  | Bacobress Ah                       | 24a. REC'D  | 8Y REGISTRAR 24b. REGISTRAR'S                         | SIGNATURE                                     |
| Chamber Funeral Ho   | ome 3072 "M" St                    | reet Washing  |   | 24  |
|  |                                    | SI  | EP 3 0 '59 arthur                                     | y & House                                     |

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TON HOUSE LET HOUSE E. W. S. Mayer B. Marin J. Marin J. Marin De. of The Ball

orate of the principal transfer to the principal transfer of the princ thember landral Hore 50 C M Street house to the the **CERTIFICATE OF DEATH** 

Reg. Dist. No.

| 1. PLACE OF DEATH<br>a. COUNTY            |  |              |                            |           | USUAL RESIDENCE (W        | here decease           | d lived. If instituti     |             | ice befa   | re admiss  | sian)              |
|---|--|--------------|----------------------------|-----------|---------------------------|------------------------|---------------------------|-------------|------------|------------|--------------------|
| MONTGOM                                   |  |              | MARYLAN                    | 10        | MARYLAND                  |                        | MONTGO                    |             |            |            |                    |
| b. CITY OR TOWN RURAL and give            | (If outside carporate liminearest tawn)              | its, write   | c. LENGTH OF STAY IN 1     | 16        | c. CITY OR TOWN (IF       | autside carpo          | orate limits, write R     | URAL and    | give nec   | orest tawr | n)                 |
| OLNEY                                     |  |              | 3 DAYS                     | X         | OLNEY                     |                        |                           |             |            |            |                    |
| d. NAME OF HOSE<br>OR INSTITUTION         | PITAL (If not in hospital, s                         | give street  | address)                   | 1         | d. STREET ADDRESS         |                        |                           |             |            | e. IS RES  | SIDENCE<br>A FARM? |
| MONTGOMER                                 | Y COUNTY GE  | NERAL        | HOSPITAL, 1                | Nd.       | Box 69                    |                        |                           |             |            |            | NOXX               |
| 3. NAME OF<br>DECEASED<br>(Type or print) | Fi   | ADYS         | Middle<br>JENNE            |           | CROSBY                    | 4. DATE<br>OF<br>DEATH | Man                       | TEMBE       | Da         |            | Year<br>19 59      |
| 5. SEX                                    |  |              | IED NEVER MARRIED          |           | TE OF BIRTH               | 1                      | 9. AGE (In years          | IF UNDER    |            |            |                    |
| FEMALE                                    | WHITE  | WIDOWI       |                            | _         | 9/7/09                    |                        | last birthday)<br>50 yrs. | Manths      | Days       | Haurs      | Min.               |
| 10a. USUAL OCCUPAT                        | ION (Give kind of work                               | dane 10b.    | KIND OF BUSINESS OR IN     | DUSTRY    | 11. BIRTHPLACE (State     | ar foreign c           | auntry)                   | 12. CIT     | IZEN C     | F WHAT     | COUNTRY            |
| Housewif                                  | orking life, even it refired                         | 1            | Own Home                   |           | NEW YOR                   |                        |                           |             | USA        |            |                    |
| 13. FATHER'S NAME                         |  |              |                            | 14        | . MOTHER'S MAIDEN I       | NAME                   |                           | ns T        |            |            |                    |
| JAMES G                                   | ARFIEDL DEG  | ARMO         |                            |           | LILLIAN                   | VIOLA                  | SPEED                     |             |            |            |                    |
| 15. WAS DECEASED EN                       | ER IN U. S. ARMED FOR                                |              | SOCIAL SECURITY NO. 1      | 7. INFO   |                           | TIVEN                  | Add                       | ress        |            |            |                    |
| (Yes, no, or unknown)                     | (If yes, give war or dates of s                      |              | 46-20-2515                 | 11        | D                         | 100                    | 0                         | M4-         |            |            |                    |
| No  |  |              |                            | HOS       | PITAL RECO                | RDS                    | ULNE                      | Y, MD       | •          |            |                    |
|   | EATH [Enter anly ane co                              | ouse ger lin | ne far (a), (b), and (c).] |           | 1-1-                      |                        |                           |             |            | ERVAL BE   |                    |
| PARI I. DI                                | EATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o            | , Ro         | en Cor c                   | - M       | lelosto                   | نمي                    |                           |             | 6          | d          | A                  |
| 170X                                      | DUE TO   |              |                            |           |                           | 1                      | 2                         |             |            | 2          | -00                |
| Conditions, if                            | any, which )   |              | 0 V                        | 0.        | Call                      | 14.1                   | DAG                       | -           |            |            |                    |
| gave rise to                              | immediate (  | 1_9-0        | granas                     | The       | v                         | ~ ~                    | on west                   |             |            |            |                    |
| cause (a), statin                         | g me under-  |              | V                          | C         |                           |                        |                           |             |            |            |                    |
|   |  |              | CONTRIBUTING TO DESTU      | BUT NOT   | DELL'ARCO TO THE TOTAL    |                        |                           |             |            |            |                    |
| PARI II. U                                | INEK SIGNIFICANI CON                                 | DITIONS      | ONTRIBUTING TO DEATH       | ROI NOI   | RELATED TO THE TERM       | INAL DISEAS            | E CONDITION GIV           | EN IN PAR   | T 1(a)   1 | PERFC      | AUTOPSY<br>DRMED?  |
| 5   |  |              |                            |           |                           |                        |                           |             |            | YES 🗌      | NO 🗌               |
| OR CONTRIBUTION                           | VAS UNDERLYING  G CAUSE OF DEATH Y MEDICAL EXAMINER) | 20b. DES     | TRIBE HOW INJURY OCCU      | RRED. (Er | ter nature of injury in   | Part I ar Par          | t II of item 18.)         |             |            |            |                    |
| N 20c. TIME OF INJU                       | JRY Manth, Day, Ye                                   | or 20d It    | JURY OCCURRED 20e          | PLACE     | OF INJURY (Home, form     | 206 (Cib               | or town)                  |             | Caucha     |            | /C4-4-3            |
| 20c. TIME OF INJU                         |  | While        | Nat while                  | factory.  | street, affice bldg., etc | :.)                    | or lawn,                  | 10          | County)    |            | (State)            |
| ₹ p. m                                    | . 19   | at war       | al wark                    |           |                           |                        |                           |             |            |            |                    |
| 21. I certify                             | that I attended the                                  | decease      | ed fram 22/11              | arle      | , 1954, to 2              | OSLI                   | 1959                      | that I      | last so    | w the      | deceases           |
| alive an /                                | 9 Sul  | 19 /         | 59 and that de             | ath occ   | urred at 5:20             |                        | n the course of           | and on a    | ha da      | A A-A      |                    |
| 0   | the same   | ^            | , and that de              | . 1       |                           |                        | treet, city ar tawn,      |             | ne da      | is zigie   | ATE CIGNES         |
| ACTUAL<br>SIGNATURE                       | lin Bo   | elw          | 3.1.                       | M.D.      | Oliv                      | ų "                    | nul                       | storej      | -          | 2/8        | 45                 |
| PHYSICIAN'S<br>NAME (Type)                | J. B. Zi   | EGLES        | 100                        |           | OLNE                      | Y. MAR                 | YLAND                     |             |            |            | 0                  |
|   | ON, 226. DATE THEREC                                 | F            | 22c. NAME OF CEMETER       | Y OR CRI  |                           |                        | TION (City, tawn, o       | or county)  |            | (State     |                    |
| Burraya (Specif                           |  |              | Gate of H                  |           |                           | Silv                   |                           | ing, M      | lary       |            |                    |
| 23. FUNERAL DIRECTO                       |  | 10-10        | ADDRESS                    | ,         | 24a. REC'                 | D BY REGIST            | RAR 24b. REGIS            | STRAR'S SIG | GNATUE     | RE         |                    |
| Tyson Whe                                 | eler-1331  | E. p         | Montg Ave                  | 4         | DATE ©                    | SEP 23                 | 59 0                      | Iriling .   | 8 th       | and        |                    |

ofter death. Page 4: PR: After this certificate has been signed by the attending physician and completely filled in by the function, etached for use as the burial-transit permit. Then please remove garbaa papers. Pages 1 and 2 should be filed with TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours may be retained by the haspital or attending physician.

TO FUNERAL DISCOR: After this certificate has been signed by the attending physician and page 3 should be detached for use as the burial-transit permit. Then please remove carbon the registrar prior to burial, cremation, ar removal, and in any event within 72 hours often de VS A15 (4) 15M 10/57

| NTARORO ST |                         |                        |   |
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|            | A. J. Leaf X. Dec. 1980 |                        |   |
|            | LONG THE LEGISLAND      | A CONTRACTOR OF STREET |   |
|            |                         | Charles of the second  |   |
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TO HOSPITAL OF may be retain:
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VS A15 (4) 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10419

CERTIFICATE OF DEATH

|   | -0114   |  |  |                                    | keg. Dist. No                                |
|---|---|--|--|------------------------------------|--|
| 1. PLACE OF DEATH<br>g. COUNTY<br>Montgom |   | MARYLAND   | 2. USUAL RESIDENCE (WHO PENNSY I VA  | nia b. COUNTY                      | ion: Residence before admission)             |
| b. CITY OR TOWN RURAL ond give            | (If outside corporate limits, write nearest town)               | c. LENGTH OF STAY IN 16  |  | outside corporate limits, write F  | RURAL and give nearest town)                 |
| Bethesd                                   | a (Rural)   | 97 days  | Turtle Cr  | reek                               | 75 x 3                                       |
| OR INSTITUTION                            |   | t oddress)   | d. STREET ADDRESS  |                                    | e. IS RESIDENC                               |
|   | al Hospital   | 1  | 350 McMas  | ters Ave.                          | YES NO                                       |
| NAME OF<br>DECEASED<br>(Type or print)    | Donald  | Carl Dunn  | CURRIE   | 4. DATE Mor                        | ember 7 1959                                 |
| SEX                                       | 6. COLOR OR RACE 7. MAR   |  | B. DATE OF BIRTH   | 9. AGE (In years<br>lost birthdoy) | Months Doys Hours Mir                        |
| Male                                      | Caucasian widow   |  | 7-5-40   | 19 yrs.                            | Months Doys Hours Mir                        |
| during most of we                         | TION (Give kind of work done 10b. orking life, even if retired) |  |  | or foreign country)                | 12. CITIZEN OF WHAT COUNT                    |
| Marine                                    | U   | .S.Marine Co   |  | ylvania                            | U.S.A.                                       |
| . FATHER'S NAME                           |   |  | 14. MOTHER'S MAIDEN N  |                                    |  |
|   | • CURRIE  |  | Dolores  |                                    |  |
| fes, no, or unknown)                      | /ER IN U. S. ARMED FORCES? 16.                                  |  | NFORMANT   | Add                                | ress   |
| Yes                                       | 9/1948 to DOD   | 203-30-3419  | Hospital   | Records                            |  |
| 18. CAUSE OF D                            | EATH [Enter only one couse per                                  | ine for (a), (b) ond (c).]   | //   | 1//                                | INTERVAL BETWEE                              |
| PART I. DI                                | EATH WAS CAUSED BY:   | with de  | 2  | Vani                               | ONSET AND DEAT                               |
| 200.0                                     | DUE TO  | The state of the s | The state of the s | - June                             | 6/10   |
| Conditions, if                            |   | 1.5  | 1.4  | 11 000                             | #  |
| gove rise to                              | immediate   | rascina  | Allicu   | dum all.                           | Cype   |
| couse (o), stotin                         | g the under- DUE TO   |  |  |                                    | 4(1)   |
| lying couse los                           |   |  |  |                                    |  |
| PART II. O                                | THER SIGNIFICANT CONDITIONS                                     | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERMI   | NAL DISEASE CONDITION GIV          | VEN IN PART 1(0) 19. WAS AUTOP<br>PERFORMED? |
| PART II. O                                |   |  |  |                                    | YES X NO                                     |
| OR CONTRIBUTION                           | VAS UNDERLYING ☐<br>G ☐ CAUSE OF DEATH<br>Y MEDICAL EXAMINER)   | SCRIBE HOW INJURY OCCURRED   | D. (Enter noture of injury in t  | Port I or Port II of item 18.)     |  |
| 20c. TIME OF INJU                         |   | l for  | ACE OF INJURY (Home, form<br>tory, street, office bldg., etc.  | , 20f. (City or town)              | (County) (Sto                                |
| p. m                                      | 10  | 1401 WIIIIG  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                                    |  |
| 21. I certify                             | hat I attended the deceas                                       | sed from June 2  | 10 59 to Se  | ptember7 159                       | that I last saw the decea                    |
| alive on Set                              | A.A 1   |  |  |                                    | nd an the date stated abo                    |
| dive dil                                  | 1-111   | and that death   |  | ADDRESS (Street, city or town,     |  |
| ACTUAL A                                  | Ille &  | 1 / Sac / 201  |  |                                    |  |
| ACTUAL SIGNATURE                          |   | SOMEO  | M.D. U. S. Na  | val Hospita                        | 9-0-59                                       |
| PHYSICIAN'S<br>NAME (Type)                | Villiam P. BAH  | KER, LT, MC, USI   | Bethesda   | , Maryland                         |  |
| 20. BURIAL, CREMATI                       | ON, 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OF   | R CREMATORY  | 22d. LOCATION (City, town,         | or county) (Stote)                           |
| urial-Sh                                  | Ipment 9-9-59   |  |  | Turtle Creek                       | . Pennsylvania                               |
|   | R'S SIGNATURE 4/ /5   | ADDRESS Wash.  | DC 24a. REC'I  |                                    | STRAR'S SIGNATURE                            |
| Thi Yn. W                                 | bers & Co., 140   |  |  |                                    | Thung & House                                |
| TATE ALLENIEL                             | SCIN OF THE   | A CHEDTH 9P  | O THAW A DAIL OF   | [ [ [ ] ]                          | Thurs & Mr. A                                |

|  | SHOULD AND HOLDING     |                   |                 |           |
|--|------------------------|-------------------|-----------------|-----------|
| 18.8   |                        |                   | 2001            |           |
|  | Pennsylvenia           |                   | Vision          | est north |
|  | 19-1. ( ) = 13 dist    | egab Ti           | (incol) cha     | 1,V3      |
| X de La | .ev. amenaskom veš     |                   | Ladicaci Esva   | M.2.5     |
| et y godnos                                    | OUR SERVICE STRING     | nast ima          | Jonald          |           |
|  | 7-5-10                 |                   | da La souge     | lislo     |
| .s.s.u -                                       | ng - Permay Lycale     | 1. C. Marilno Gar | 9.1             | LuaM (    |
|  | Dolores V. Dunk        |                   | o, cumpra       | agent,    |
|  |                        |                   |                 |           |
|  | te Vradnya cada ge i û | ر آ ہوں ا         |                 |           |
|  | Tou:II as a            |                   | d reduction     |           |
| 1 ( )  | U. S. Hoval Haplt      |                   | K was a second  |           |
|  |                        | . dazw            | General Pages 1 |           |
|  | 9. Walland 1981 . e    |                   | ( B = 1         |           |

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|---|----|---|---|---|
| L | U  | 9 | U | 8 |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. COUNTY Montgomery b. COUNTY Montgomery MARYLAND Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chewy Chase Chevy Chase unobtainable d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? OR INSTITUTION 106 Primrose Street Primrose Street YES NO M NAME OF 4. DATE Middle Lost Month DECEASED CURTISS Wilhelmina (Type or print) DEATH 9. AGE (In years last birthdoy)
59 yrs. B. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours white female WIDOWED T DIVORCED [ 10a. USUAL OCCUPATION (Give kind af work dane) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (state or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Tilinois U. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Hoch unobtainable Address Chevy Chase . Md. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Charles Lewis Curtis 106 Primrose St. no no 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO

ONSET AND DEATH couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) WAS AUTOPSY NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) foctory, street, affice bldg., etc.) Hour o. m. While Not while of work at work

21. I certify that I attended the deceased from MAY 10 , 1954, to 19.79, that I last saw the deceased and that death occurred at ... M. fram the causes and on the date stated above.

VOCATION (City, town, or county)

ADDRESS (Street, city or town, state)

(State)

REMOVAL (Specify)
Burial 23. FUNERAL DIRECTOR'S SIGNATURE

Arlington Nat'l

Arlington. Virginia 24a, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

ACTUAL PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION.

S. H. Hines Co. Washington, D. C.

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| lonn sead words                         |                      |               |     |
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| ginindaik i minu                        |                      | Health Health | 301 |
| Common of List eland                    | 0.0000000            |               |     |
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| John Mech                               | LATAGE               |               |     |
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| AND |                      |               |     |
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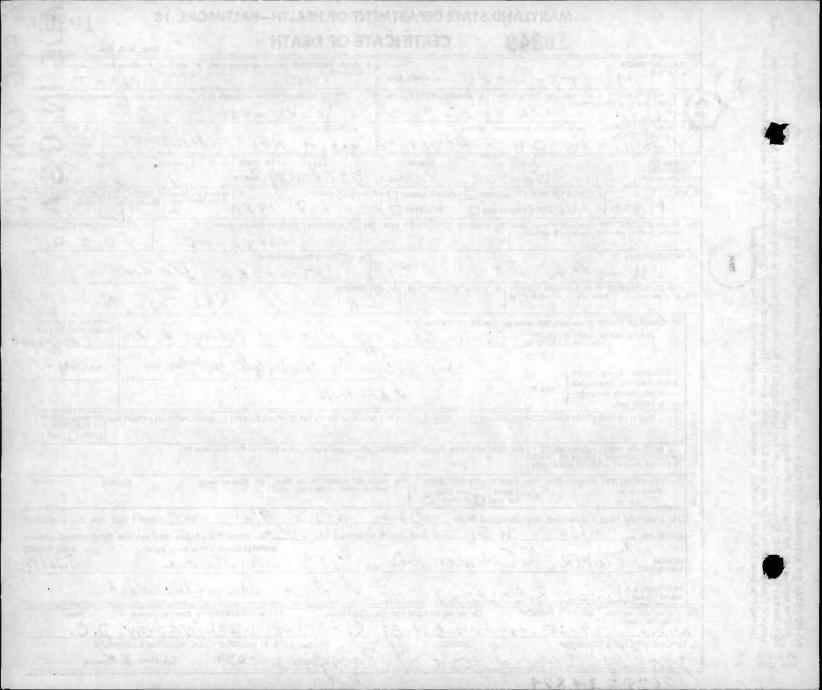
VS A1S (4) 1SM 10/57

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| MARYLAND | STATE DEPARTMENT | OF HEALTH-BALT | IMORE, 18 | ß |
|----------|------------------|----------------|-----------|---|
|----------|------------------|----------------|-----------|---|

10349 CERTIFICATE OF DEATH

| ~  | 20                              |  | Res   | g. Dist. No.  |
|--|---------------------------------|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGO   | MERY MARYL                      | O STATE  | nere deceased lived. If institution: Re<br>b. COUNTY            | esidence befare admission) McNT.                    |
| b. CITY OR TOWN (If autside carporate lin RURAL and give nearest tawn)                         | 2 1 2                           | 5/0  | nutside carporate limits, write RURAL                           | and give nearest town)                              |
| d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION WASHINGTON S                           | 1/                              | TAL HOLL H   | SPEN HILL   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO X           |
| DECEASED   | irst Middle ALTER GER           | HLD DEGROVEH   | 4. DATE Month of DEATH  | Day Year 26 1959                                    |
|  | WIDOWED DIVORCED                | O SEPT 7   | 1959 last birthday) Mar   | NDER 1 YEAR IF UNDER 24 HRS.  Onths Days Haurs Min. |
| 10o. USUAL OCCUPATION (Give kind of wark<br>during most of working life, even if retire        | dane 10b. KIND OF BUSINESS OR   |  | ar fareign country)  ARYLAND                                    | 2. CITÍZÉN OF WHAT COUNTRY? $U - S \setminus A$ ,   |
| 13. FATHER'S NAME  WALTER  | DE GROVEN                       | 14. MOTHER'S MAIDEN N  | ABEL DEA  | PN  |
| 1S. WAS DECEASED EVER IN U. S. ARMED FO<br>(Yes. no. or unknown) (If yes, give wor or dates of | RCES? 16. SOCIAL SECURITY NO.   | 7. INFORMANT A 05PITA  | L RECORDS   | W 5. 1 H.   |
| 18. CAUSE OF DEATH [Enter only one of PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE             | (Men. Til                       | hypoplasia   | of kidneys, tilo  | INTERVAL BETWEEN ONSET AND DEATH CANSENCE           |
| Canditions, if any, which gave rise to immediate cause (a), stating the under-                 | on complice                     | the by electr  | olyte imbolance   | 5 days.   |
| lying couse last.  | c)                              | H BUT NOT RELATED TO THE TERMI                                       | nal disease condition given in                                  | N PART 1(a) 19. WAS AUTOPSY PERFORMED?              |
| PART II. OTHER SIGNIFICANT COI   | 206. DESCRIBE HOW INJURY OC     | CURRED. (Enter nature of injury in I                                 | Part I or Part II of item 18.)                                  |   |
| 20c. TIME OF INJURY Month, Day, Y. Haur a. m. 19   | while Not while at wark at wark | 20e. PLACE OF INJURY (Hame, farm factory, street, affice bldg., etc. | 20f. (City or town)   | (County) (State)                                    |
| 21. I certify that I attended the alive on 9/26  | 57                              |  | AM, from the causes and a ADDRESS (Street, city or town, state) |   |
| PHYSICIAN'S JAMES R  | COLEMAN                         | Silver   | Apring Mary   | plant.  |
| 220. BURIAL, CREMATION, 22b. DATE THERE REMOVAL (Specify) 9-28-                                | OF 22c. NAME OF CEMET           | TET CEMETERY   | 22d. YOCATION (City, lawn, ar cou                               | onty) (State)                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE   | end Home mi                     | V /0   | D BY REGISTRAR 24b. REGISTRAR                                   | r's signature<br>ng & Khama                         |
| 12075 234 XV4  |                                 | mg.  |   |   |



VS A1S (4) 15M 9/S8

| MARYLAND                                     | STATE DEPARTM                      | ENT OF HEALTH—BALTIMORE, 18  |
|--|------------------------------------|--|
| 10350  | CERTIFICA                          | ATE OF DEATH   |
| ery  | MARYLAND                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: o. STATE b. COUNTY.) |
| ide carporote limits, write<br>tawn)<br>Pack | c. LENGTH OF STAY IN 16<br>81 days | c. CITY OR TOWN (If outside corporate limits, write RUR)                       |

# CERTIFICATE OF DEATH

|  | keg. Dist. No.  |
|--|---|
| 1. PLACE OF DEATH O. COUNTY MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence befare admission) o. STATE b. COUNTY  |
| b. CITY OR TOWN (If autside carporote limits, write RURAL and give nearest town)   | mon the many  |
| Takoma Pork 81 days  | 17 AKOMA Pack   |
| d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION  Wash  San + Hosp.  | d. STREET ADDRESS  on a FARM?  SUS DOMER AUE.  e. 15 RESIDENCE ON A FARM? YES \( \) NO BY YES \( \) NO BY   |
| 3. NAME OF First Middle  | Last 4. DATE Month Day Year   |
| (Type or print)    11/ane Catherine    6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | 195 y 195 y 195 y 195 y 195 y 196 y |
| Female Caue . WIDOWED DIVORCED   | last birthday) Manths Days Haurs Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Admin. Asst. 4.5. 20  of Garic.               |   |
| 3. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME  |
| William Exectz   | Mary Keischel   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.  (Yes, no, or unknown)   If yes, give war or dates of service)   none | H6310, tal Records  |
| 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  199.2  DUE TO | Odenvearcinamic Interval Between Onser and Death Thoulton   |
| Canditions, if any, which gave rise to immediate cause (o), stoting the <u>under-lying cause lost.</u> (b)  DUE TO  (c)                    |   |
|  | BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS' PERFORMED? YES \( \sum \) NO \( \sum \)  |
| 20g. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCUR OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)        | RRED. (Enter nature af injury in Part I or Port II af item 18.)   |
| 20c. TIME OF INJURY Manth, Doy, Yeor 20d. INJURY OCCURRED Hour a. m. p. m. 19 While at wark at wark at wark                                | PLACE OF INJURY (Hame, farm, foctory, street, office bldg., etc.) (Caunty) (State of town) (Caunty)   |
| 21. I certify that attended the deceased fram free alive an Sept 6   | 20, 1959, ta 1959, that I last saw the decease of the accurred at 130 M, from the causes and an the date stated above.  ADDRESS (Street, city of town, state)  DATE SIGNE   |
| ACTUAL George Willeam Ware   | M.D. 900- 17 4 14 h. W  |
| PHYSICIAN'S GEORGE WILLIAM WARE  | Warley for De   |
| 22c. NAME OF CEMETERY BURIAL Specify) 9/10/59 PARKLAWN CEMETERY  | Y OR CREMATORY 22d. LOCATION (City, town, or caunty) (State) METERY MONTGOMERY COUNTY, MARYLAND   |
| WHYNERAL DIRECTOR'S SIGNATURE INC. SILVER SPRI   | ING, MD. PATE SFP 9 '59 Cathon & Harris   |

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VS A1S (4) 15M 9/SS

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# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH 10292

|      |      | 4  | 1 | 9 | 7 | 4 |
|------|------|----|---|---|---|---|
| Reg. | Dist | No | U | J | 6 | 1 |

| PLACE OF DEATH O. COUNTY   | MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. o. STATE Maryland   | COLLETT  |  |
|--|--|---|--|--|
| Montgomery   |  |   |  | gomery   |
| RURAL and give nearest town)   | NGTH OF STAY IN 16                                   | c. CITY OR TOWN (If outside corporate lim   | nits, write RURAL and give   | e nearest town)  |
| Silver Springs, Md 9   | days   | 56 Silver Springs.  | Md.  |  |
| <ul> <li>NAME OF HOSPITAL (If nat in haspital, give street address<br/>OR INSTITUTION</li> </ul>   | )  | d. STREET ADDRESS   |  | e. IS RESIDENCE<br>ON A FARM?  |
| St Philmena rest home  |  | 417 Windsor St  |  | YES NO T   |
| NAME OF DECEASED (Type or print) wentred   | Middle H . [   | ObRin 4. DATE OF DEATH  | Month<br>Sept 18   | Day Year<br>, 1959 <sub>19</sub>   |
| SEX   6. COLOR OR PACE 7. MARRIED  | NEVER MARRIED  | B. DATE OF BIRTH 9. AGE   | E (In years   IF UNDER 1 Y   |  |
| female white WIDOWED   | DIVORCED [   | Oct 10, 1879 79   | yrs. Months Do   | oys Hours Min.   |
| Do. USUAL OCCUPATION (Give kind of work done 10b, KIND (   | OF BUSINESS OR INDUS                                 |   | 12. CITIZE   | N OF WHAT COUNTRY  |
| during most of working life, even if refired) Housewife own  | home   | New York  | US   | A  |
| . FATHER'S NAME  | Home   | 14. MOTHER'S MAIDEN NAME  | 0.5  | **   |
| James C. Higgins   |  | Mary J. Johnson   |  |  |
| . WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL  | SECURITY NO. 117 H                                   | NFORMANT  | Address  |  |
| fes, no. or unknown)   {If yes, give wor or dates of service}  |  |   |  | ma Ma  |
| no non   | е ма   | rie D Mc Callam Si  | lver Spring  | gs, Ma.  |
| PART I. DEATH WAS CAUSED BY:   |  | 1/ ///  | 77   | ONSET AND DEATH  |
| Conditions, if any, which gove rise to immediate couse (a), stoling the under.  DUE TO  DUE TO  DUE TO  DUE TO   | erteuswe.  | arteriosclerate &   | lisian   | approx 25y   |
| Conditions, if any, which gove rise to immediate cause (a), stoting the under-lying cause lost.  DUE TO  DUE TO  (c)   | ertensure BUTING TO DEATH BUT                        | Arteriosclerates D  | DITION GIVEN IN PART I   | approx 25y  (o) 19. WAS AUTOPSY PERFORMED? YES NO []   |
| Conditions, if any, which gove rise to immediate couse (o), stoting the under:    Part II. OTHER SIGNIFICANT CONDITIONS CONTRI   200. ACCIDENT WAS UNDERLYING   CONTRIBUTIONS   CAUSE OF DEATH   CONTRIBUTIONS   CONTRIBUTIONS   CAUSE OF DEATH   CONTRIBUTIONS   CAUSE OF DEATH   CAUSE OF DEAT |  | NOT RELATED TO THE TERMINAL DISEASE CONE  O. (Enter nature of injury in Port I or Part II of it   |  | PERFORMED?   |
| Conditions, if any, which gove rise to immediate cause (o).  DUE TO  Conditions, if any, which gove rise to immediate cause (o), stotling the under:  Iying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRI  20a. ACCIDENT WAS UNDERLYING CONTRIBUTIONS CONTRIBUTI | OCCURRED 20e. PLA fac                                |   | tem 18.)   | PERFORMED?<br>YES NO   |
| Conditions, if any, which gove rise to immediate cause (o).  DUE TO  Conditions, if any, which gove rise to immediate cause (o), stotling the under.  Iying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRI  20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year Mour a. m.  P. m.  19 of work at  | OCCURRED 20e. PU fact twork 2                        | O. (Enter nature of injury in Port I or Part II of it  ACE OF INJURY (Home, form,   20f. (City or tow tary, street, office bldg., etc.)   | (Cou   | PERFORMED? YES NO (Stote)  Inty) (Stote)  St saw the deceased date stated abave                  |
| Conditions, if any, which gove rise to immediate couse (a), stoting the under lying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS   CAUSE OF DEATH OR CONTRIBUTIONS   CONTRIB | OCCURRED 20e. PU fact twork 2                        | ACE OF INJURY (Home, form, large) 20f. (City or tow large, street, office bldg., etc.)  20f. (City or tow large) 19.57, to 9.57, to 9.57, from the  | (Cou   | PERFORMED? YES NO (Stole)  Inty) (Stole)   |
| Conditions, if any, which gove rise to immediate couse (o), stoting the under:    DUE TO   | OCCURRED 20e. PL/ fact while a work 1 and that death | ACE OF INJURY (Home, form, larger II of it and the state of the state | in) (Cou   | PERFORMED? YES NO (Stote)  Inty) (Stote)  St saw the deceased date stated abave                  |
| Conditions, if any, which gove rise to immediate cause (o).  DUE TO  Conditions, if any, which gove rise to immediate cause (o), stotling the under.  Ilying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRI  20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year Mour a. m.  p. m.  19 of work of work of alive on Contribution of the work of the | OCCURRED 20e. PL/ face 1 work 20                     | ACE OF INJURY (Home, form, larger II of it and the state of the state | (Country 18.)  The state of the | PERFORMED? YES NO (Stote)  Inty) (Stote)  St saw the decease date stated abave DATE SIGNE 9/18/5 |

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|                        | Test ment state and  |          |  |
|                        | Total Marie Salaria  |          |  |
|                        | Total March  |          |  |
|                        | Total Maria Carlos   |          |  |

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

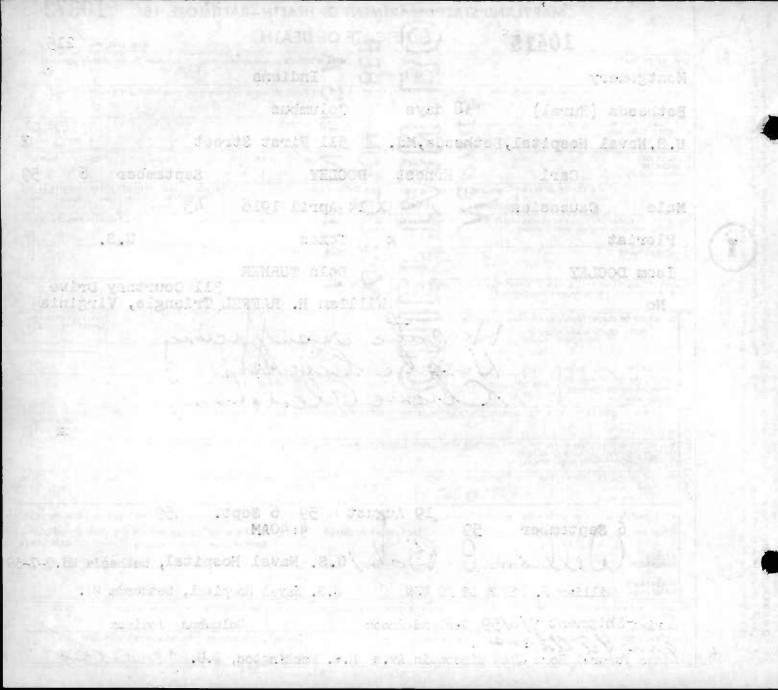
CEPTIEICATE OF DEATH

|   | 10415  | Reg. Dist. No. 215          |                               |   |                                 |  |  |
|---|--|-----------------------------|-------------------------------|---|---------------------------------|--|--|
| n. PLACE OF DEATH<br>g. COUNTY<br>Montgome  | ry   | MARYLAND                    | 2. USUAL RESIDENCE (W         | here deceased lived. If institution b. COUNTY | on: Residence before admission) |  |  |
| b. CITY OR TOWN<br>RURAL and give           | (If outside corporate limits, write nearest town)                | c. LENGTH OF STAY IN 16     | c. CITY OR TOWN (IF           | outside corporate limits, write R             | URAL and give nearest town)     |  |  |
| Bethesda                                    |  | 18 days                     | Columbus                      |   | 12 X-3                          |  |  |
| d. NAME OF HOSE<br>OR INSTITUTION           | ITAL (If nat in haspital, give stree                             | oddress)                    | d. STREET ADDRESS             |   | e. IS RESIDENC<br>ON A FARM     |  |  |
| U.S. Nava                                   | 1 Hospital, Be   | thesda, Md.                 | 511 Firs                      | t Street                                      | YES NO                          |  |  |
| B. NAME OF<br>DECEASED                      | First  | Middle                      | Last                          | 4. DATE Man                                   |                                 |  |  |
| (Type or print)                             | Carl   | Ernest                      | DOOLEY                        | DEATH Septe                                   |                                 |  |  |
| 5. SEX                                      | 6. COLOR OR RACE 7. MAR  |                             | B. DATE OF BIRTH              | 9. AGE (In years last birthdoy)               | Months Days Hours Min           |  |  |
| Male  | Caucasianvidov   |                             |                               | .916 43 yrs.                                  |                                 |  |  |
| Oo. USUAL OCCUPAT<br>during most af wo      | TON (Give kind of wark done 10b<br>orking life, even if retired) | . KIND OF BUSINESS OR INDUS | TRY 11. BIRTHPLACE (Stat      | e or foreign country)                         | 12.CITIZEN OF WHAT COUNT        |  |  |
| Florist                                     |  | k                           | Texas                         |   | U.S.                            |  |  |
| 3. FATHER'S NAME                            |  |                             | 14. MOTHER'S MAIDEN           | NAME  |                                 |  |  |
| Isom DO                                     | OLEY   |                             | Lola TUR                      |   |                                 |  |  |
| 5. WAS DECEASED EV<br>(Yes, no, or unknown) | ER IN U. S. ARMED FORCES? 16                                     | SOCIAL SECURITY NO.         | FORMANT                       |   | rtney Drive                     |  |  |
| No  |  | Wi                          | lliam H. F                    | AFFEL Triang                                  | le, Virginia                    |  |  |
| 18. CAUSE OF DE                             | EATH [Enter anly one cause per I                                 | me far (a), (b), and (c).   |                               | V X   | INTERVAL BETWEEN                |  |  |
| PART I. DE                                  | EATH WAS CAUSED 8Y:  | Je Dalie                    | Man                           | Micienes                                      | ONSET AND DEAT                  |  |  |
| 581.1                                       | DUE TO   | 11 1                        | N.                            | XX  |                                 |  |  |
| Canditions, if                              | ony, which ) (b)   | hoalis                      | KINA                          | 100 -   |                                 |  |  |
| gove rise to                                | immediate (  |                             | 0//                           | 1119.   |                                 |  |  |
| lying couse last                            |  | Scome.                      | aller                         | Laliani                                       |                                 |  |  |
| PART II. O                                  | THER SIGNIFICANT CONDITIONS                                      | CONTRIBUTING TO DEATH BUT   | NOT RELATED TO THE TER        | MINAL DISEASE CONDITION GIV                   | EN IN PART 1(a) 19. WAS AUTOP   |  |  |
| PART II. O                                  |  |                             |                               |   | PERFORMED? YES NO               |  |  |
| L DO- ACCIDENT VA                           | VAS UNDERLYING   20b. DE   | SCRIBE HOW INJURY OCCURRED  | ). (Enter nature of injury in | Part I ar Port II af item 18.)                |                                 |  |  |
| OR CONTRIBUTION                             | G CAUSE OF DEATH   |                             |                               |   |                                 |  |  |
| 20c. TIME OF INJU                           | JRY Month, Day, Yeor 20d.  |                             | CE OF INJURY (Home, for       |   | (Caunty) (Sto                   |  |  |
| 20c. TIME OF INJU                           | 10   | Not while foo               | tory, street, office bldg., e | tc.)  |                                 |  |  |
|   |  |                             | at . 50 6                     | Cont FO                                       |                                 |  |  |
|   | that I offended the decea  | sed from 19 Augu            | 18 L, 19 29 to C              | Sept. 1929                                    | that I last sow the decea       |  |  |
| alive on O                                  | September, 19  | 59_, ond that death         | occurred ot 4:40              |   | d on the dote stoted abo        |  |  |
| Acres (                                     | 1. (///  | D (2 1/                     | 1                             | ADDRESS (Street, city or town,                |                                 |  |  |
| ACTUAL<br>SIGNATURE                         | Ulllan   | 1) Jako                     | MD U.S. Nav                   | al Hospital,                                  | Bethesda Md.9-7                 |  |  |
| PHYSICIAN'S                                 |  |                             |                               |   |                                 |  |  |
| NAME (Type)                                 | Villiam P. BAKER   | LT MC USN                   | U.S. Nava                     | al Hospital, Be                               | thesda Md.                      |  |  |
| 220. BURIAL, CREMATI                        | ON, 22b. DATE THEREOF  | 22c. NAME OF CEMETERY O     | CREMATORY                     | 22d. LOCATION (City, town,                    | or county) (State)              |  |  |
| REMOVAL (Specif<br>Burial S                 | ipment 9/8/59  | Garland Brook               |                               | Columbus I                                    | ndiana                          |  |  |
| 3. FUNERAL DIRECTO                          | R'S SUSTIATURE   | ADDRESS                     | 24o. REG                      | C'D 8Y REGISTRAR 24b. REGIS                   | STRAR'S SIGNATURE               |  |  |
| Greek                                       | peral Home 1718  | Wisconsin Arr e             | N LI LIDATE                   | acton D.G                                     | Oslus & Kraus                   |  |  |

funeral director, uld be filed with death. Page 4 and campletely filled in by the funeral TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours may be retain. The hospital or oftending physician.

TO FUNERAL DY. FOR: After this certificate has been signed by the attending physician and campletely filled in by page 3 shauld be detached far use as the burial-transit permit. Then please remove copera appears. Pages 1 and 2 the registrar priar to burial, cremation, ar remaval, and in any event within 72 hours of ther death.

VS A15 (4) 15M 9/58



ST. TROMPEAN HEATH SO THINTENESS STATE OF ACTION IS A LEWIS CONTROL OF THE PARTY OF THE LANDING THE PARTY OF the state of the second of the state of the second

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VS A15 (4) 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 10417 CERTIFIC   | CATE OF DEATH  Reg. Dist. No.   |
|--|---|
| 1. PLACE OF DEATH  o. COUNTY  Montgomery  MARYLANE   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY District of Columbia |
| b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15  |   |
| Kensington, Md.  | 47x-3   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
| Carroll Hall Nursing Home  | 3725 Macomb Street, N. W. YES NO  |
| 3. NAME OF DECEASED (Type or print) EVA STID HA  | M DOUGALC DEATH SENTENCE 10 1959  |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   | 8. DATE OF BIRTH 9. ACE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.  |
| female white WIDOWED TO DIVORCED   | Feb. 19, 1876 83 yrs. 10018 Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done of the during most of working life, even if retired)   | OUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY  |
| housewife  | Philadelphia, Pa.   |
|  | 14. MOTHER'S MAIDEN NAME  |
|  | Hannah M. Gardiner  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 (Yes, no. or unknown) (If yes, give wor or doles of service)   | . INFORMANT Address   |
|  | 3725 Macomb St., N. W.  |
|  | Washington, D. CINTERVAL BETWEEN  |
| IMMEDIATE CAUSE (a)  | EROIC HEARI DISEASE   |
| 420.0 DUE TO   |   |
| Conditions, if any, which (b) CHRONIC  | MYOCARAITIS   |
| LACE OF DEATH COUNTY  MARYLAND  MARYLAND  MONTE OTHER  DISTRICT OF COlumbia  C. CITY OR TOWN (If outlide corporate limits, write BURAL and give nearest town)  DISTRICT OF COlumbia  C. CITY OR TOWN (If outlide corporate limits, write BURAL and give nearest town)  MARYLAND  DISTRICT OF COlumbia  C. CITY OR TOWN (If outlide corporate limits, write BURAL and give nearest town)  d. STREET ADDRESS  OR INSTITUTION  AND STREET ADDRESS  OR INSTITUTION  DIVING TOWN (If outlide corporate limits, write BURAL and give nearest town)  DIVING COR INSTITUTION  DIVING TOWN (If outlide corporate limits, write BURAL and give nearest town)  d. STREET ADDRESS  OR INSTITUTION  AND STREET ADDRESS  OR INSTITUTION  DIVING TOWN (If outlide corporate limits, write BURAL and give nearest town)  DIVING COR INSTITUTION  DIVING TOWN (If outlide corporate limits, write BURAL and give nearest town)  DIVING COR INSTITUTION  DIVING TOWN (If outlide corporate limits, write BURAL and give nearest town)  d. STREET ADDRESS  ON A FAIL  LOAD TOWN (If outlide corporate limits, write BURAL and give nearest town)  DO NO A FAIL  DATE OF BURN IN USE ADDRESS  ON A FAIL  DATE OF BURN IN USE ADDRESS ON INDUSTRY IN BURN IN B |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH B  | CERTIFICATE OF DEATH   Reg. Dist. No.   |
|  |   |
| OR CONTRIBUTING LI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | RED. (Enter nature of injury in Port I or Part II of item 18.)  |
| Hour a. fr. While Not while  | PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) foctory, street, office bldg., etc.)                        |
| 21. I certify that I attended the deceased from SEPT 7   | 1957 to Vent 10 1959 that I lost saw the decease  |
|  |   |
| William III  |   |
| SIGNATURE Henry fourten  | M.D. 0206 Warery 107.   |
| PHYSICIAN'S NAME (Type)  | Cherry Chory las  |
| REMOYAL_(Specify)  | (30.0)  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| ( H. Irule m of 2847 Wilson Blv  | day Cirling & Thouse  |

| ALTH-BALIMORE, 18  | ENT OF HE     |              |                  |                                   |
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|  |               |              | 7.<br>7.<br>4    |                                   |
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|  |               |              |                  | And American                      |
|  |               |              | The Land         |                                   |
|  |               |              |                  | C. C.                             |
|  | A. W.         |              |                  | Same Challenger at 1.15           |
| SID-Listoff Linb of an bed several of the 1991 To an art of the 19 | arin hankasa  |              |                  | CCCC MANUAL                       |
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| The state of the s |               | 0.01-10.0349 |                  | THE RESIDENCE OF THE PARTY OF     |
|  |               |              |                  | the state of the town or disease. |

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10351 **CERTIFICATE OF DEATH**

10375 Reg. Dist. No

|         | PLACE OF DEATH a. COUNTY  Montgomery   | MARYLAND                              | 2. USUAL RESIDENCE<br>o. STATE                           | (Where deceased lived.<br>b                                    | If institution: Resid            |                | sion)  |
|---------|--|---------------------------------------|--|--|----------------------------------|----------------|--|
|         | b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)                                   | c. LENGTH OF STAY IN 16               | as all 1   | (If autside carporate lim                                      | nits, write RURAL and            |                | n) V   |
|         | d. NAME OF HOSPITAL (If nat in hospital, give stree OR INSTITUTION Samt)   | t address)<br>Hosp                    | d. STREET ADDRE  | ss XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                         | KATAN KOKAK<br>KATAN KOKAK       | ON A           | e. Is RESIDENCE ON A FARM? YES NO 1959  IF UNDER 24 HRS Haurs Min. WHAT COUNTRY!  WHAT COUNTRY!  (State  The deceased a stated abave bate signer Stated abave bate signer (State)  (State) |
|         | NAME OF DECEASED (Type or print)  Wifferd  | Middle<br>Hall                        | Dunn   | 4. DATE<br>OF<br>DEATH   | Month<br>Sept                    | 47.1           | 120  |
| S.      | SEX 6. COLOR OR RACE 7. MAR  Cave WIDOW  | RRIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH   | 9. AGE last  | (In years IF UND birthdoy)  yrs. | Doys Haurs     | T  |
| 3       | i. USUAL OCCUPATION (Give kind of work dane 10b during most of working life, even if retired)  PATHERS NAME        |                                       | - 1  |  | 12. C                            | MSA            | COUNTRY  |
|         | George Dunn  |                                       | Mary   | ane xxxxxx   |                                  | IK .           |  |
|         | s, no, or unknown) (If yes, give war or dates of service)  | 578-10-9997                           | HESP REL   | rords  | Address                          |                |  |
| CATION  | PART II. OTHER SIGNIFICANT CONDITIONS  | Preumo:<br>teriociteration            | emorrhe<br>Carlova<br>I NOT RELATED TO THE               | rminal  ge  Scular DH  TERMINAL DISEASE CONF                   | DITION GIVEN IN PA               | ONSET AND      | AUTOPSY<br>DRMED?  |
| CERTIFI | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | SCRIBE HOW INJURY OCCURRE             |  |  |                                  |                |  |
| MEDICAL | Hour o.m. While  | - 1                                   | act OF INJURY (Home<br>ectary, street, office bldg       | , form, 20f. (City ar taw<br> -, etc.)                         | n)                               | (County)       | (State   |
|         | 21. I certify that I attended the decea alive and part 2 1 19 19 ACTUAL SIGNATURE DATE James M. Whitle NAME (Type) | 9 1, and that death                   | , 1957, to<br>n accurred off 14<br>M.D. 770/ CO<br>Paker | Sept 2/<br>PAM, from the co<br>ADDRESS (Street, ci<br>MO// HVM |                                  | he date stated | d abave  |
| 220     | D. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 9/24/59   | 22c. NAME OF CEMETERY C               |  |  | COUNTY                           |                | te)  |
|         | FUNERAL DIRECTOR'S SIGNATURE VARNER E. PUMPHREY, INC.  | ADDRESS<br>SILVER SPRING              | 24a.   | REC'D BY REGISTRAR<br>E SEP 2 4 '59                            | 24b. REGISTRAR'S                 | SIGNATURE      |  |

TO FUNERAL DISCOR: After this certificate has been signed by the attending physician and campletely filled in by mrs funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban pages. Pages 1 and 2 shauld be filled with the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. r death. Page ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs TO HOSPITAL OR VS A1S (4) 1SM 9/SB

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| The Carlotte State of Carlot   | Mary Company             | 25.7          | Andrew Street  |           |
| For the  | Duritte                  | NAW.          | San Heritage   |           |
|  | 23:425                   |               |                |           |
| EL ASS.  |                          |               | all among the  | Delining. |
| TOT ALTER  | e rett eren              |               | HI KEL GET     | come of   |
|  | and July                 |               |                |           |
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|  | 12.72                    |               | TO NA          | The same  |
| 4-4-016  | Targett , age .          |               |                |           |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Calley S. Frank

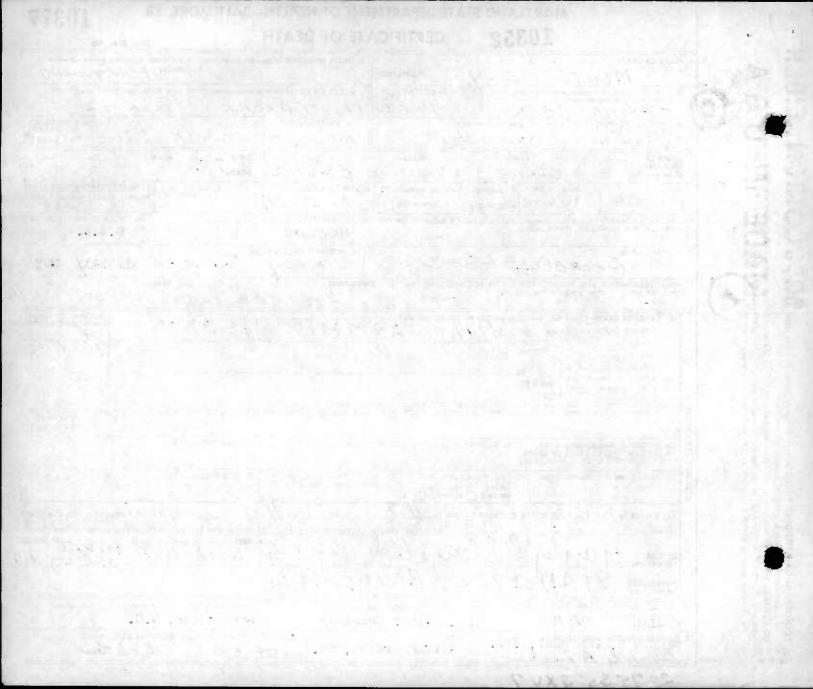
| L             |   | 104  | 18         | CEKI                      | IFICA      | TE OF DEA                                     | HIL                 |                 |                               | Reg. D     | ist. No          |           | 0.00               |
|---------------|---|--|------------|---------------------------|------------|---|---------------------|-----------------|-------------------------------|------------|------------------|-----------|--------------------|
| 1             | n. COUNTY Montgomer   |  |            | MAR                       | YLAND      | 2. USUAL RESIDENCE<br>a. STATE<br>Onio        | E (Where            | deceased fiv    | ed. If instituti<br>b. COUNTY | on: Reside | nce befo         | re odmis  | ssian)             |
| L             | b. CITY OR TOWN (II RURAL and give ne   | f autside carporate lim                        | its, write | c. LENGTH OF STA          | YINIb      | c. CITY OR TOWN                               | (If autsid          | le carporate    | limits, write R               | URAL and   | give ne          | arest taw | n)                 |
| L             | Bethesda  |  |            | 24 day                    | S          | Cincinna                                      | ti                  |                 | 7                             | 2 X        | 3                |           |                    |
|               | OR INSTITUTION  | AL (If not in hospital, cal Center             |            | Charles Co. of Co. of Co. | Md.        | d. STREET ADDRES                              |                     | venue           |                               |            |                  | ON        | SIDENCE<br>A FARM? |
| 3             | NAME OF   | Fi   |            | Middl                     |            | Lost  |                     | DATE            | Man                           | th         | Do               |           | Year               |
|               | (Type or print)   | Sand   | ira        | Mari                      | 0          | Eckstei                                       |                     | OF<br>DEATH     | Septe                         |            |                  |           | 19 59              |
| S             | . SEX   | 6. COLOR OR RACE                               |            |                           |            | . DATE OF BIRTH                               |                     | 9. /            | AGE (In years                 |            |                  |           | ER 24 HRS.         |
|               | Female  | White  | WIDOWI     |                           |            | October 6,                                    | 193                 |                 | 19 yrs.                       | Manths     | Days             | Haurs     | Min.               |
| 10            | On USUAL OCCUPATIO  | N (Give kind of work                           | dane 10h   |                           | OR INDUST  | TRY 11. BIRTHPLACE (                          | State or fo         | reign caunt     |                               | 12. CI     | TIZEN C          | )F WHA    | T COUNTRY          |
|               | Stenograp   | ing life, even if refired                      | )          | Communicat                |            | and the second                                | Ohio                |                 |                               |            |                  | S.A.      |                    |
| /\\ri         | . FATHER'S NAME   | 1101   | ,          | Johnstitteau              | 10113      | 14. MOTHER'S MAID                             |                     |                 |                               |            | 0.               | J.R.      | -                  |
|               | Joseph F  | Eckstein                                       |            |                           |            | Valda St                                      | onho                | ne              |                               |            |                  |           |                    |
| 15            | . WAS DECEASED EVER   |  | CES? 16.   | SOCIAL SECURITY N         | O. 117. IN | FORMANT The M                                 |                     |                 | Add                           | 2015       |                  | -         |                    |
| 10            | No (  | If yes, give war or dates of s                 | ervice)    | ascertaina                |            | The Clinic                                    |                     |                 |                               |            | 11.              | Mo        | dand               |
| -             |   | TH [Enter only one or                          |            |                           |            | THE OTHITC                                    | al U                | enter           | Decile                        | oua.       |                  |           |                    |
|               | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  MMEDIATE CAUSE (a)  Septicemia |  |            |                           |            |   |                     |                 |                               |            | INTERVAL BETWEEN |           |                    |
| П             | 20110   | IMMEDIATE CAUSE (c                             | /          | POTCOME                   |            |   | -                   |                 |                               |            |                  | 24 H      | lours              |
|               | 204,3   | DUE TO   |            |                           |            |   |                     |                 |                               |            |                  |           |                    |
|               | Canditians, if ar   | nmediate                                       |            | ute Myelog                | enous      | Leukemia                                      |                     |                 |                               |            | -                | O M       | lonths             |
|               | lying cause last.   | he under-                                      | )          |                           |            |   |                     |                 |                               |            |                  |           |                    |
| 2             |   | ED SIGNIFICANT CON                             |            | Chitpiputing to be        | CATH BUT N | HOT BELLETED TO THE                           |                     | DIST. 05.00     |                               |            |                  |           |                    |
| CESTIFICATION | TXII II. OIN  |  | DITIONS C  | ONIKIBUTING TO DI         | EATH BOTT  | NOT RELATED TO THE T                          | EKMINAL             | DISEASE CC      | NDITION GIV                   | EN IN PAI  | RT 1(a) 1        | PERFC     | DRMED?             |
|               |   | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES   | CRIBE HOW INJURY          | OCCURRED.  | . (Enter nature of injur                      | y in Part I         | ar Part II a    | of item 18.)                  |            |                  |           |                    |
| MEDICAL       | 20c. TIME OF INJURY<br>Hour a. m.   | Month, Day, Ye                                 | While      | JURY OCCURRED  Nat while  | 20e. PLA   | CE OF INJURY (Home, ory, street, affice bldg. | farm, 20<br>, etc.) | Of. (City or t  | awn)                          | (          | (County)         |           | (State)            |
| 1             |   |  | at warl    | <del></del>               | 1 01       | 50  |                     |                 | 38 86                         |            |                  |           |                    |
| H             | 21. I certify the   | at I attended the                              | deceas     | ed framAugus              | t 24       | , 19.59, ta                                   | Septe               | ember           | 171959                        | _,that I   | last so          | w the     | deceased           |
|               | alive an Sept   | ember 17                                       | , 19       | 9 , and tha               | t death    | accurred at 7                                 | 112AM               | , fram th       | e causes a                    | nd an t    | he da            | te stat   | ed abave           |
|               |   | 1 0  | 0-4        | 2 1                       | 1          |   |                     |                 | city or town,                 | stote)     |                  | D         | ATE SIGNED         |
|               | SIGNATURE CO  | Mur 13   | John       | man M                     | )M         | The Clin                                      |                     |                 | -                             |            |                  | 9/17      | 1/59               |
|               | PHYSICIAN'S AF  | RTHUR R. RO                                    | AMH TC     | N. M.D.                   |            | National<br>Bethesda                          |                     | titute<br>Mary] | s of H<br>Land                | ealt       | h                |           |                    |
| B             | BURIAL, CREMATION   | n, 22b. DATE THEREC                            | 8-59       | 22c. NAME OF CEA          | AETERY OR  | CREMATORY                                     | 22d.                | LOCATION        | (City, town, o                | r county)  | Ohi              | O (Stat   | le)                |
| 23            | . FUNERAL DIRECTOR'S  |  | Pares      | ADDRESS                   | 3          |   | REC'D BY            | REGISTRAR       | 24b. REGIS                    | TRAR'S SI  | GNATU            | ₹E        |                    |
|               | = Movert  | - (a. temys                                    | y          | Bethesda                  | a, Md      | DATE  | SEP 2               | 1 '59           | Cint                          | Lun &      | France           | A         |                    |

ATENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 funeral directar, should be filed with by the haspital ar attending physician.

[OR: After this certificate has been signed by the attending physician and campletely filled in by detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remayal, and in any event within 72 haurs after death TO HOSPITAL OR may be retained TO FUNERAL D page 3 shaula

VS A15 (4) 15M 10/57

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| ot a market by the annual state of the state |   |                      |                       |  |
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| 2/11/58<br>Sent th   | indred Lacintal wife,   |                      |                       |  |
|  | hat lead his about he   | .C. T                |                       |  |
| e de la companya de l | Fitte remission Fit   |                      | 31-9 110-147-146      |  |
|  |   | A Sanat Son          |                       |  |



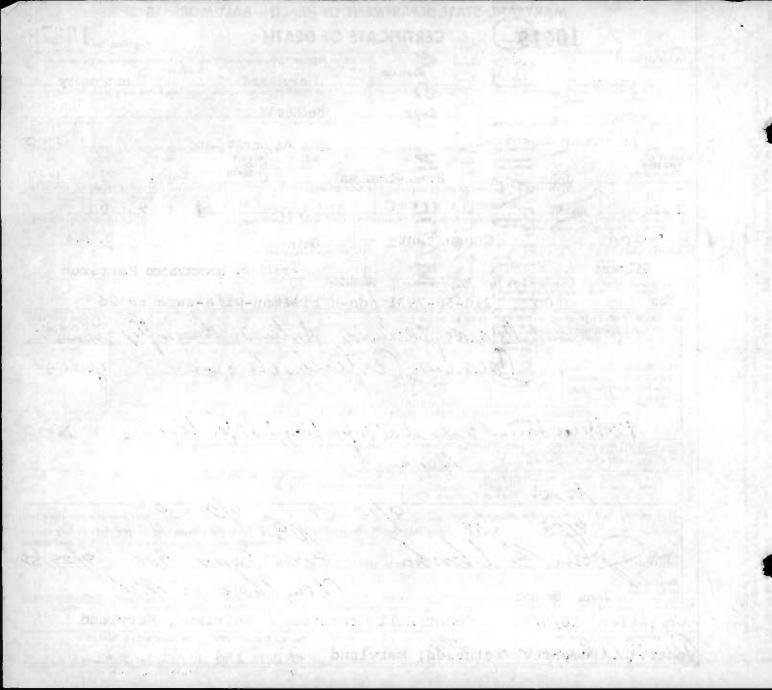
# er death. Page 4 in by the funeral directar, and 2 should be filed with ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haur y the haspital ar attending physician. may be retain by the haspital ar attending physician. TO FUNERAL COR: After this certificate has been signed by the attending physician and camplet page 3 shauld be detached far use as the burial-transit permit. Then please remave carban popers. the registrar prior to burial, crematian, ar remaval, and in any event within 72 haurs after death. TO HOSPITAL OR

VS A1S (4) 1SM 9/SB MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10419

## **CERTIFICATE OF DEATH**

|   | M ontromery  | MARYLAND                | o. STATE  Mary                    | b. COUNTY                              | M ontgomery                      |  |  |  |  |  |  |  |
|---|--|-------------------------|-----------------------------------|--|----------------------------------|--|--|--|--|--|--|--|
|   | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   | LENGTH OF STAY IN 16    |                                   | utside corporate limits, write RU      |                                  |  |  |  |  |  |  |  |
| - | d. NAME OF HOSPITAL (If not in hospital, give street odd   | 17 days                 | Bethesd  d. STREET ADDRESS        | a                                      | - IS DESIDENCE                   |  |  |  |  |  |  |  |
| , | OR INSTITUTION   | aress)                  | d. SIREET ADDRESS                 |  | e. IS RESIDENCE<br>ON A FARM?    |  |  |  |  |  |  |  |
| - | Suburban Hospital  |                         | 4514 Am                           | herst Lane                             | YES NO X                         |  |  |  |  |  |  |  |
|   | 3. NAME OF First DECEASED (Type or print)  | Middle<br>H. Eise       | lost<br>m an                      | 4. DATE Month<br>OF<br>DEATH Sept      |                                  |  |  |  |  |  |  |  |
|   |  |                         | 8. DATE OF BIRTH                  | 9. AGE (In years lost birthdoy)        | IF UNDER 1 YEAR IF UNDER 24 HRS. |  |  |  |  |  |  |  |
|   | Male White WIDOWED   | DIVORCED                | 12/23/07                          | 61 yrs.                                | Months Days Hours Min.           |  |  |  |  |  |  |  |
| 1 | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | ND OF BUSINESS OR INDUS | STRY 11. BIRTHPLACE (Stote        | or foreign country)                    | 12. CITIZEN OF WHAT COUNTRY?     |  |  |  |  |  |  |  |
|   |  | nsultant                | Ohio                              |  | U. S.A                           |  |  |  |  |  |  |  |
| J | 3. FATHER'S NAME   | 1100200110              | 14. MOTHER'S MAIDEN N             | IAME                                   |                                  |  |  |  |  |  |  |  |
| 1 | Gilbert M. Eiseman   |                         | Arel                              | i S. Meerokabon                        | n Hartsron                       |  |  |  |  |  |  |  |
| 1 |  | CIAL SECURITY NO.       | NFORMANT                          | Addre                                  |                                  |  |  |  |  |  |  |  |
| 1 | (Yes, no. or unknown) (If yes, give war or dates of service) Yes Army 21   | 8-38-7931 A             | da H Eilena                       | an-wife-same                           | as 2d                            |  |  |  |  |  |  |  |
| ŀ | 18. CAUSE OF DEATH [Enter only one couse per line f  |                         | IGG II DIGERE                     | All Will Duine                         | INTERVAL BETWEEN                 |  |  |  |  |  |  |  |
| 1 | PART I. DEATH VENT ONSET AND DEATH PART I. DEATH WAS CAUSED BY MONEY AND DEATH ONSET AND DEATH MANDUATE CAUSE (6) PROVIDENCE AND DEATH ONSET AND DEATH ONSET AND DEATH   |                         |                                   |  |                                  |  |  |  |  |  |  |  |
|   | 420. Due to  |                         |                                   |  |                                  |  |  |  |  |  |  |  |
| 1 | Conditions, if ony, which) (b) (see on men (Isterions lessis) ileans   |                         |                                   |  |                                  |  |  |  |  |  |  |  |
| 1 | gove rise to immediate   | read c                  | vavoue                            | eur un                                 | - Gecons                         |  |  |  |  |  |  |  |
|   | couse (o), stoting the <u>under-</u> DUE TO  lying couse lost.   |                         |                                   |  |                                  |  |  |  |  |  |  |  |
|   | , (-)  |                         |                                   |  |                                  |  |  |  |  |  |  |  |
| 2 | Covered Latina Mycandral Infaction, left lentine PERFORMED?  |                         |                                   |  |                                  |  |  |  |  |  |  |  |
|   | PART HOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THETERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?  YES NO  200. ACCIDENT WAS UNDERLYING   20b. DESCRIBE NOW INJURY OCCURRED. (Enter noture of injory in Part I or Port II of item 1B.)  OR CONTRIBUTING   CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER) |                         |                                   |  |                                  |  |  |  |  |  |  |  |
|   |  | JRY OCCURRED 20e. PL    | ACE OF INJURY (Home, form         | , 20f. (City or town)                  | (County) (State)                 |  |  |  |  |  |  |  |
|   | Hour o. m. While of work   | 1401 MILLS              | ctory, street, office bldg., etc. |  |                                  |  |  |  |  |  |  |  |
| 1 | 21. I certify that I attended the deceased   | (3/                     | 12 1959 to                        | 9/29 1059                              | that I last saw the deceased     |  |  |  |  |  |  |  |
| 4 | alive on 9/29 19 5   | and that death          | 12/5                              |  | d on the date stated above.      |  |  |  |  |  |  |  |
| 1 |  | , did illal dedill      | 113 4                             | ADDRESS (Street, city or town, s       |                                  |  |  |  |  |  |  |  |
|   | ACTUAL SIGNATURE   | bonham                  | M.D. 8805                         | Conn. A                                | ve. 9/29/59                      |  |  |  |  |  |  |  |
|   | PHYSICIAN'S  |                         | 0/-                               | N                                      | 101                              |  |  |  |  |  |  |  |
| 1 | NAME (Type) John Um hau  |                         | ( be Citing !                     | K250 13 1                              | 17 CV.                           |  |  |  |  |  |  |  |
|   |  | 2c. NAME OF CEMETERY O  |                                   | 22d. LOCATION (City, town, o Suitland, | maryland (Stote)                 |  |  |  |  |  |  |  |
|   | 23 FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                 |                                   |  | TRAR'S SIGNATURE                 |  |  |  |  |  |  |  |
| 1 | 6/6/   | Hesdal Mary             | land DATE OF                      |  | Thur & Kraus                     |  |  |  |  |  |  |  |
| Ł |  |                         |                                   | 1 6 99 1 Cm                            | Lower of Thomas                  |  |  |  |  |  |  |  |



may be retain TO FUNERAL D TO HOSPITAL

VS A1S (4) 1SM 9/SB

No.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10420

**CERTIFICATE OF DEATH** 

| 1. PLACE OF DEATH o. COUNTY MONTGOMERY   | MARYLAND                 | 2. USUAL RESIDENCE (Where o. STATE MARYLANI                   |   | MONT GOM              |                                   |
|--|--------------------------|---|---|-----------------------|-----------------------------------|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  KENSINGTON   | c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (If outsi                                     | ide corporote timits, write RU<br>PRING | URAL and give nearest | town)                             |
| d. NAME OF HOSPITAL (If not in hospitol, give street of OR INSTITUTION Carden:   | oddress)  8 Nursing Home | d. STREET ADDRESS / 11,610 GEORG                              | GIA AVENUE                              |                       | RESIDENCE<br>ON A FARM?<br>S NO S |
| 3. NAME OF First DECEASED (Type or print) EMM A  | Middle                   | Engling 4.  | DATE Mont<br>OF DEATH                   | th Day                | Yeor 1959                         |
| S. SEX 6. COLOR OR RACE 7. MARR  | DIVORCED DIVORCED        | B. DATE OF BIRTH /  | 9. AGE (In years lost birthdoy) 80 yrs. | Months Days Ho        | JNDER 24 HRS.<br>Durs Min.        |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  none  | KIND OF BUSINESS OR INDU | STRY 11. BIRTHPLACE (Slole or                                 |   | 12.CITIZEN OF WH      |                                   |
| 13. FATHER'S NAME ALFRED FISCHER   |                          | SUZANNE PHIL  | Lips ()                                 |                       |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                          | Marion E. Jac   | cobsen, 11,61                           | O Ga. Ave.            |                                   |
| 1B. CAUSE OF DEATH [Enter only one couse per lin PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate  | Lemoly                   | Pobor Pn<br>Partinos  | eliver claver                           |                       | 4 hou                             |
| couse (a), stoting the under-<br>lying couse lost.   |                          |   |   |                       | elles                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONDIT | ONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINA                                    | l disease condition giv                 | PI                    | AS AUTOPSY ERFORMED?              |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | CRIBE HOW INJURY OCCURRE | D. (Enter noture of injury in Port                            | I or Port II of ilem 18.)               |                       |                                   |
| Occ. TIME OF INJURY Month, Doy, Year 20d. IN While p. m. 19 of work  | Not while fo             | ACE OF INJURY (Home, farm, ctory, street, office bldg., etc.) | 20f. (City or town)                     | (County)              | (Stote)                           |
| 21. I certify that lattended the decease olive an  | and that death           | occurred of 2 0 5/4M<br>M.D. 106 20                           | /                                       |                       |                                   |
| PHYSICIAN'S MICHAEL M. DOEBE   | RIDGE /                  | feli  | er fforin                               | y hel.                |                                   |
| 220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 9/10/59   | PROSPECT HILL            | CEMETERY 22   | WASHINGTON,                             | D.C.                  | (Stote)                           |
| 23 FARMER PURPHREY, INC.   | STLVER SPRIN             | G, MD.  |   | STRAR'S SIGNATURE     |                                   |

TALEBURE HEATTE The state of the second THE MALE WAS ARREST OF THE STATE OF THE STAT The Department of Lina (City City Control of ATTENDED TO A STATE OF THE STAT 

| IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  |
|---|
| by be retoined by the haspitol or ottending physician.  UNERAL DI OR. After this certificate has been signed by the attending physician and completely filled in by fineral director.  The desired by the high transfer the build have been signed by the other properties of the build have been at the build have been been at the build have been at |
| registrar prior to burial, cremation, or remayal, and in any event within 72 hours after death.   |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10380 10421 **CERTIFICATE OF DEATH** 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND Montgomery District of Columbia b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Bethesda davs Washington d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? The Clinical Center. Bethesda li. Md. 906 - 3rd Street. S.E. YES NO TO First Middle 4. DATE DECEASED (Type or print) James Richard English DEATH September 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years lost birthdoy) 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS Months DIVORCED TO Male Negro WIDOWED | 1,0 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Nurses Aide Hospital Virginia U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Robert English Annie Tinsley 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Record Address Yes WWII 223-12-0600 The Clinical Center, Bethesda ll, Maryland 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), pnd (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY 2 PERFORMED? YES TO NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of ilem 18.) 20c. TIME OF INJURY Month. Day, Year 20d INSURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) Hour a.m. foctory, street, office bldg., etc.) While Not while of work p. m 19 59, to September 6, 19 59, that I last saw the deceased 21. I certify that I attended the deceased from August 28 alive on September 6 and that death accurred at 2:05 Am, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL The Clinical Center National Institutes of Health Charles E. Mengel, M. D. PHYSICIAN'S Bethesda ll. Maryland NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) Pulaski, Va. New River. 9-11-59 Pod 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Rockville. Md. DATE P 1 0 '59 Cirthun & Kroup 15M 10/57

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(Stote)

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VS A15 (4) 1SM 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10422 **CERTIFICATE OF DEATH** 

| 1. PLACE OF DEATH  COUNTY  Montgome      |   |             | MARYLAND                         | 2. USUAL RES                               | IDENCE (WI                   | ere deceased l   | ived. If instituti<br>b. COUNTY | on: Residenc    | e before admis  | sion)              |
|--|---|-------------|----------------------------------|--|------------------------------|------------------|---------------------------------|-----------------|-----------------|--------------------|
| b. CITY OR TOWN<br>RURAL and give        | (If outside corporate limit nearest town)             | s, write    | c. LENGTH OF STAY IN 16          | c. CITY OR                                 | TOWN (If o                   | utside corporo   | te limits, write R              | URAL ond g      | ive nearest tow | n)                 |
| Bethesda                                 |   |             | 88 days                          | The  | Dist                         | rict of          | Columb                          | ia 4            | -7x-3           |                    |
| d. NAME OF HOSP<br>OR INSTITUTION        | ITAL (If not in hospital, gi                          | ve street c | oddress)                         | d. STREET                                  | ADDRESS                      |                  |                                 |                 |                 | SIDENCE<br>A FARM? |
| The Clin                                 | ical Center   | Bet         | hesda ll. Md.                    | 531  | O Chil                       | llum Pl          | ace. N.                         | E.              |                 | NO S               |
| 3. NAME OF<br>DECEASED                   | Firs  | t           | Middle                           | La   |                              | 4. DATE          | Mon                             |                 | Day             | Yeor               |
| (Type or print)                          | Agne  |             | Irene                            | Far  | rah                          | DEATH            | Sept                            | ember           | 25.             | 1959               |
| 5. SEX                                   | 6. COLOR OR RACE                                      | 7. MARRI    | ED T NEVER MARRIED               | 8. DATE OF BIRT                            | Н                            | 9.               | AGE (In years<br>lost birthdoy) |                 | YEAR IF UND     |                    |
| Female                                   | White   | WIDOWE      | D DIVORCED                       | July 23                                    | . 1916                       | 5                | 13 yrs.                         | Months          | Doys Hours      | Min.               |
| 10a. USUAL OCCUPAT                       | ION (Give kind of work durking life, even if retired) | one 10b. 1  | KIND OF BUSINESS OR INDI         | ISTRY 11 BIRTHE                            | LACE (State                  | or foreign cour  | ntry)                           | 12. CITI:       | ZEN OF WHA      | COUNTRY            |
| Housewif                                 | e & Cashie  | r           | Wene-Sho                         | 0  | Mis                          | souri            |                                 |                 | U. S.           | A .                |
| 13. FATHER'S NAME                        |   |             |                                  | 14. MOTHER'S                               | MAIDEN N                     | IAME             |                                 |                 |                 |                    |
| Charles !                                | Ketchum   |             |                                  |  | Els                          | ie Hen           | dricks                          |                 |                 |                    |
| 15. WAS DECEASED EV                      | ER IN U. S. ARMED FORC                                | ES? 16. S   | SOCIAL SECURITY NO. 17.          | INFORMANT T                                | he Med                       | lical R          | ecord Add                       | ress            |                 |                    |
| No                                       |   |             | 98-16-8589                       | The Clin                                   |                              |                  |                                 |                 | Maryl           | and                |
| 18. CAUSE OF DE                          | ATH [Enter only one cou                               | se per lin  |                                  |  |                              |                  |                                 |                 | INTERVAL B      | ETWEEN             |
| PART I. DE                               | ATH WAS CAUSED BY:                                    | Gas         | trointestinal                    | Hemorrh                                    | age                          |                  |                                 |                 | ONSET AND       |                    |
| 2043                                     | DUE TO  |             |                                  |  |                              |                  |                                 |                 |                 | ,                  |
| Conditions, if                           |   | Acu         | te Myelogenou                    | s Leukem                                   | ia                           |                  | ii,                             |                 | 6 Mon           | nths               |
| gove rise to couse (o), stating          |   |             |                                  |  |                              |                  |                                 |                 |                 |                    |
| lying couse lost.                        |   |             |                                  |  |                              |                  |                                 |                 |                 |                    |
| PART II. O1                              | THER SIGNIFICANT COND                                 | ITIONS CO   | ONTRIBUTING TO DEATH BU          | T NOT RELATED TO                           | THE TERMI                    | NAL DISEASE C    | CONDITION GIV                   | EN IN PART      | 1(0) 19. WAS    | AUTOPSY            |
| S GassGa                                 | ngrene of Bo  | wel.        | Liver, with                      | Clostrid                                   | ium Se                       | pticem           | ia                              |                 |                 | NO                 |
| OR CONTRIBUTION                          | G CAUSE OF DEATH MEDICAL EXAMINER)                    | 20b. DESC   | RIBE HOW INJURY OCCURR           | ED. (Enter noture o                        | of injury in f               | ort I or Port II | of item 18.)                    |                 |                 |                    |
| ZOc. TIME OF INJU<br>Hour o. m.<br>p. m. | 10  | While       | JURY OCCURRED  Not while of work | LACE OF INJURY (<br>octory, street, office | lHome, farm<br>e bldg., etc. | 20f. (City or    | r town)                         | (Ce             | ounty)          | (Stote)            |
| 21. I certify t                          | hat I attended the                                    | decease     | d from June 2                    | 9 1959                                     | . toSep                      | tember           | 25 1959                         | that I le       | ast saw the     | decense            |
| alive on S                               | eptember 25   | 195         |                                  | h accurred at                              | 10:001                       | M from           | the course o                    | and on the      | e data etat     | ad above           |
| (1)                                      | 10  | 10          | . /                              |  | ,                            | ADDRESS (Street  | et, city or town,               | stote)          |                 | ATE SIGNED         |
| ACTUAL SIGNATURE                         | unand C   | - 100       | echannel                         | MA   |                              |                  | nical Co                        |                 | 9/2             | 26/59              |
|  |   |             |                                  |  |                              |                  | l Instit                        |                 | of Heal         | th                 |
| PHYSICIAN'S<br>NAME (Type)               | RICHARD C. M  | <b>ECHA</b> | NIC, M.D.                        |  |                              |                  | a 14. Ma                        |                 |                 |                    |
| 220. BURIAL, CREMATIC<br>Burial (Specify | ON, 226. DATE THEREOF                                 |             | Arlington 1                      |  |                              | 22d. LOCATIO     | N (City, town, o                | or county)      | (Sto            | e)                 |
| 23. FUNERAL DIRECTOR                     | R'S SIGNATURE   |             | ADDRESS                          |  |                              | BY REGISTRA      | -                               | TRAR'S SIGN     |                 |                    |
| The S.H.H                                | Hines Co.   | 290]        | ing ton 9.D                      | A.C.W.                                     |                              | 2 8 '59          |                                 | tur J. 7        |                 |                    |
|  |   | W S S       | TIME VOIL 70D.                   |  | DAIL SE                      | 3 7 8 33         | C:10                            | a series of the | 0.404           |                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs are a dearn may be retained the haspital or attending physician.

TO FUNERAL DIM OR: After this certificate has been signed by the attending physician and campletely filled in by are funeral page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 shauld be the registror prior to burial, cremation, or removal, and in any event within 72 haurs ofter death.

VS A15 (4) 15M 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10423 **CERTIFICATE OF DEATH**

|    |      | 1  | U | 3 | Ö | 4 |
|----|------|----|---|---|---|---|
| 00 | Dist | No |   |   |   |   |

|   | 1. PLACE OF DEATH o. COUNTY  |            |   | NCE (Where decease    |                                    | on: Residence b | efore admissi | ion)             |  |
|---|--|------------|---|-----------------------|------------------------------------|-----------------|---------------|------------------|--|
|   | Montgomery   | ARYLAND    | o. STATE                                | aryland               | b. COUNTY                          | Montge          | omery         |                  |  |
|   | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   | AY IN 1b   |   | WN (If outside corp   | orote limits, write R              | URAL ond give   | nearest town  | )                |  |
|   | Bethesda 2 hrs. 5  | 0 min      | X Kei                                   | nsington              |                                    |                 |               |                  |  |
|   | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |            | d. STREET AD                            | DRESS                 |                                    |                 | e. IS RESI    | DENCE<br>FARM?   |  |
| 4 | Suburban Hospital  |            | 111112 L                                | und Place             |                                    |                 |               | NO 🔀             |  |
|   | 3. NAME OF First Mid   | ldle       | Last                                    | 4. DATE               | Mon                                | ith             | Day Y         | ear .            |  |
|   | (Type or print) Rose C   | F          | itzgeralo                               | DEATH                 | September                          | r 17            | 1             | 9 59             |  |
|   | 5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MA  |            | 8. DATE OF BIRTH                        |                       | 9. AGE (In years<br>lost birthdoy) | IF UNDER 1 YE   |               |                  |  |
|   | Female White WIDOWED DIVOR   | RCED 🗌     | 11/9/                                   | 88                    | 70 yrs.                            | Months Doy      | rs Hours      | Min.             |  |
| _ | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINES during most of working life, even if retired)                               | S OR INDUS | TRY 11. BIRTHPLA                        | CE (State or foreign  | country)                           | 12. CITIZEN     | OF WHAT C     | OUNTRY?          |  |
|   | none Housewel  | e          | ma                                      | cos                   |                                    | 4.              | SA            | . ,              |  |
|   | 13 FATHER'S NAME   |            | 14. MOTHER'S M                          | MAIDEN NAME           | may 1                              | in n            | nelle         | M                |  |
| - | HotRick Cronn  |            |   | unkno                 | to by a                            | Cur 11          | 19/00         | N                |  |
|   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY (Yes, no, or unknown) [ (If yes, give war or dates of service)   10 - 144 - 2 | 190 2 I    | NFORMANT                                |                       | Add                                | ress            | P             | 10               |  |
|   | (les, no, or unknown) (If yes, give war or dates of service) 019-14-3  | m          | rs. Morn                                | ran E. E.             | tall 's                            | 1100.0          | done          | 2 m              |  |
|   | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and  | (c).]      |   | 118                   | 2 5                                | di              | TERVAL BE     | TWEEN            |  |
|   | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Clerite   | ight?      | reds Hee                                | ut farle              | 4. Con Ps                          | Mounte          | 10 me         | - 10 -           |  |
|   | 443X DUE TO 60 0 11 15   |            |   |                       |                                    |                 |               |                  |  |
|   | Conditions, if ony, which) (b) Chelsus   |            | -                                       |                       |                                    |                 |               |                  |  |
|   | gove rise to immediate couse (o), stating the under-   | 470        | 11/                                     |                       |                                    |                 | 2             |                  |  |
|   | lying couse lost. (c) Clileur  | len        | 2                                       |                       |                                    |                 | 1             |                  |  |
|   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO  | DEATH BUT  | NOT RELATED TO T                        | HETERMINAL DISEA      | SE CONDITION GIV                   | EN IN PART 1(o  | 19. WAS A     | AUTOPSY<br>RMED? |  |
| 4 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO  | ~          |   |                       |                                    |                 |               | NO 🗆             |  |
|   | 20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OR CONTRIBUTING   CAUSE OF DEATH   | OCCURRE    | ). (Enter noture of i                   | njury in Port I or Po | rt II of item 18.)                 |                 |               |                  |  |
|   | (IF EITHER, NOTIFY MEDICAL EXAMINER)   |            |   |                       |                                    |                 |               |                  |  |
|   | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of work  |            | ACE OF INJURY (Hotory, street, office b | ome, form, 20f. (Cit  | y or town)                         | (Coun           | ty)           | (Stote)          |  |
|   | Hour o. m.  p. m.  19  While Not while of work of work   | ,,,,       | nory, sireer, office i                  | July Sic.             |                                    |                 |               |                  |  |
|   | 21. I certify that I attended the deceased fram.   | _          | 1959                                    | to Sept               | -17 . 195                          | That I last s   | aw the de     | eceased          |  |
|   |  | at death   |   | M, fram               |                                    |                 |               |                  |  |
|   |  |            |   |                       | Street, city or town,              |                 |               | E SIGNED         |  |
|   | SIGNATURE Slave Thenhe MD  |            | M.D. 105                                | 11 Sun                | mit B                              | ve s            | sef.          | 18.19            |  |
| 1 | DI WEIGHANIE   |            |   | 12                    | -6                                 | 111             |               |                  |  |
|   | PHYSICIAN'S George Sharpe, M.D.  |            |   | Rem                   | my m                               | ma              | <u></u>       |                  |  |
|   | 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF C   |            |   |                       | TION (City, town,                  |                 | (Stote        |                  |  |
| I | ur-Eransit 9/18/59 St. Pa  | itric      | ks                                      | Fal                   | l River                            | , Massa         | achus         | etts             |  |
|   | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   |            |   | 4a. REC'D 8Y REGIS    | TRAR 24b. REGI                     | STRAR'S SIGNA   | TURE          | 1-5-1            |  |
|   | Robert A. Pumphrey Bethesda  | , Ma       | ryland                                  | ATE SEP 21            | 50                                 |                 |               |                  |  |

WALESTER SE DECEMBER ATTORNE OFFICE TOWN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10383 10353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. cremation Shauld 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY O. STATE MARYLAND b. CITY OR TOWN (It outside aprporate lin c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) . NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? dir C YES NO NAME OF First Middle DATE Last Month Day Year DECEASED (Type or print) DEATH 2 195 retained far 2 with the S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years B. DATE OF BIRTH IFUNDER TYEAR IF UNDER 24 HRS. last birthday) Months Days Hours WIDOWED D DIVORCED T yrs. 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? oug dyring most of working life, even if retired) ass pe pub 13. FATHER'S NAME may 14. MOTHER'S MAIDEN NAME Pages 0 Y 50 ono aIS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Give 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which alang gove rise to immediate cause DUE TO (o), stating the underlying couse last. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY S PERFORMED? NO IT 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) PRIMARY | or CONTRIBUTING CAUSE OF DEATH. shauld 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) ing the w factory, street, affice bldg., etc.) Haur While Nat while m p. m. 1954 ot wark of wark 21. I certify that I took charge of the remains described above, held an Autopsy []. Inspection X Inquiry and find that ECTOR: Suicide death resulted from: Natural causes Accident X, Homicide . Undetermined cause DEPUTY MEDICAL ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER cute the cert farwarded 5 FUNERAL ASSISTANT MEDICAL EXAMINER **EXAMINER'S** 3hoschalt NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR PREMATORY 22d. LOCATION (City, lawn, on county) EMOVAL (Specify) 0 Juna ADDRESS EUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 5 246. REGISTRAR'S, SIGNATURE VS. A15ME(5) A Thraces DATE 5M 9/55

THE COURT OF THE SHOOT WALKERS TO THE RESIDENCE OF THE SHOOT OF THE SHOT OF THE SHOOT OF THE SHOOT OF THE SHOOT OF THE SHOOT OF THE SHOT OF THE SHOOT OF THE SHOOT OF THE SHOOT OF THE SHOOT OF THE SHOT They have been a Light of the second of the Children on the desirement SHAM DENTALE TRANSPORT TO SERVE

TO HOSPITAL OR may be retain TO FUNERAL DI

VS A15 (4) 15M 9/5B

the registrar priar

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH** 

|   | 1042  | 4                              | CERTIFIC                         | ATE OF DE   | ATH        |                        |   | Reg. Dist     |        | 0304                                     |
|---|---|--------------------------------|----------------------------------|---|------------|------------------------|---|---------------|--------|--|
| 1. PLACE OF DEATH o. COUNTY   | Montgom   | ery                            | MARYLAND                         | 2. USUAL RESIDER<br>o. STATE                                  | NCE (Whe   |                        | lived. If institution b. COUNTY         | on: Residence |        |  |
| b. CITY OR TOWN (If o<br>RURAL ond give near                              | utside corporote limit<br>est town)                                   | s, write                       | LENGTH OF STAY IN 16             | c. CITY OR TO   | WN (If ou  | utside corpor          | ote limits, write R                     |               |        | 4  |
| d. NAME OF HOSPITAL   | thesda  | ve street oc                   | 4 weeks, 2 d                     | d. STREET ADD   |            | ither                  | anntg                                   |               | e 19   | RESIDENCE                                |
| OP INICITITION  | uburban H   |                                |                                  |   |            | lerick                 | Ave.                                    |               | 0      | N A FARM?                                |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                 | Firs<br>Con   |                                | Middle<br>L.                     | Fletcher  |            | 4. DATE<br>OF<br>DEATH | Septemb                                 | _             | 6, Day | Yeor<br>19 59                            |
| 5. SEX<br>Male  | White   | 7. MARRIE                      | DIVORCED                         | B. DATE OF BIRTH<br>December                                  | 31,        | 1893                   | P. AGE (In years last birthday)  5 yrs. | 7             |        | JNDER 24 HRS<br>ours Min.                |
| 10a. USUAL OCCUPATION during most of working Carpenter                    | (Give kind of work d<br>life, even if retired)                        | one 10b. Ki                    | ND OF BUSINESS OR INDU           | JSTRY 11. BIRTHPLAC<br>Maryl                                  |            | or foreign co          | untry)                                  | US            |        | AT COUNTRY                               |
| 13. FATHER'S NAME   | 1777  |                                |                                  | 14. MOTHER'S M.   |            |                        | 707 J1.                                 |               |        |  |
| Lyman C.  |   | es le co                       |                                  |   | arah       | E.                     | Fletch                                  |               |        |  |
| 15. WAS DECEASED EVER II (Yes, no. ocunknown) (If )                       | ves, give war or dates of se  |                                | S214-18-83                       | nformant<br>74ora H. F  | Metc       | her (                  | Add<br>vife)                            | ress          |        |  |
| DE CONTRIBUTING (IF EITHER, NOTIFY ME                                     | DUE TO  SIGNIFICANT CONE  UNDERLYNG ID  CAUSE OF DEATH DICAL EXAMINER | 206. DESCR                     | CINEMA OF NTRIBUTING TO DEATH BU | ED. (Enter noture of in                                       | njury in P | noc<br>ort I or Port   | Hocke<br>II of item 18.)                | ZEN IN PART   | P      | VAS AUTOPSY<br>ERFORMED?<br>S NO         |
| 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.                                | Month, Doy, Yea   | r 20d. INJ<br>While<br>of work | Not while fo                     | LACE OF INJURY (Hostory, street, office b                     |            |                        | or town)                                | (Co           | ounty) | (Stote                                   |
| 21. I certify that alive an sept actual signature Physician's NAME (Type) | lattended the   | -, 125<br>gold                 | _                                | , 19 <u>59</u> ,<br>h accurred at <u>5</u><br>M.D. <u>/83</u> | 4ºh        |                        |   | d an the      |        | ne deceased<br>ated above<br>DATE SIGNED |
| 220. BURIAL, CREMATION, REMOVAL (Specify)                                 | 9/18/5  | F                              | 22c. NAME OF CEMETERY.           | OR CREMATORY  |            |                        | ON (City, town,                         | re.           | Md     | (Stote)                                  |
| 23. FUNERAL DIRECTOR'S S  | GIGNATURE   | , 3.                           | ADDRESS                          | mad.  | 4g. REC'D  | SEP 1                  |   | STRAR'S SIGI  |        | 44                                       |

sent to each of the sent to th Tallera E. O gara. (1) 14 ( 

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VS A15 (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10425 CERTIFICATE OF DEATH

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|   |   |            |                    |                    |  |                        |                  | was, pist    |           |   |
|---|---|------------|--------------------|--------------------|--|------------------------|------------------|--------------|-----------|---|
| 1. PLACE OF DEATH  o. COUNTY  Montgome      | ry  |            | MAR                | RYLAND             | 2. USUAL RESIDENCE (V<br>o. STATE<br>District          |                        | L COLLLIEV       | n: Residence | before    | admission)                                  |
|   | If outside corporate limi                         | ts, write  | c. LENGTH OF STA   | Y IN 16            | c. CITY OR TOWN (IF                                    |                        |                  | RAL and giv  | ve neores | st town)                                    |
| Bethesda                                    | eorest lown)                                      |            | 52 day             | rs                 | Washington   | n                      | 11               | 7 x = 3      | 3         |   |
| d. NAME OF HOSPI<br>OR INSTITUTION          | TAL (If not in hospital, g                        | ive street |                    |                    | d. STREET ADDRESS                                      |                        |                  | ///          | e.        | IS RESIDENCE                                |
|   | ical Center                                       | , Bet      | thesda 14,         | Md.                | 1633 L St  | reet, N.W              | •                |              |           | ON A FARM?                                  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |   | rence      | Orell              | lia                | Fong   | 4. DATE<br>OF<br>DEATH | Septen           |              | Day<br>4  | Yeor<br>19 <b>59</b>                        |
| 5. SEX                                      | 6. COLOR OR RACE                                  | 7. MARR    | HED IN NEVER MARK  | RIED 8.            | DATE OF BIRTH  | 9. A                   |                  |              |           | UNDER 24 HRS                                |
| Female                                      | White   | WIDOW      | _                  |                    | March 14, 19   | 908                    | 57 yrs.          | Months D     | oys H     | lours Min.                                  |
| 10a. USUAL OCCUPATION during most of wor    | ON (Give kind of work king life, even if retired  | done 10b.  | KIND OF BUSINESS   | OR INDUST          | RY 11. BIRTHPLACE (Stot                                | e or foreign country   | )                | 12. CITIZ    | EN OF     | WHAT COUNTR                                 |
| Secretar                                    |   |            | Administr          | ative              | Ala  | abama                  |                  | 1            | U.S       | 3 .A.                                       |
| 13. FATHER'S NAME                           |   |            |                    |                    | 14. MOTHER'S MAIDEN                                    | NAME                   |                  |              |           |   |
| David M.                                    | Gardiner  |            |                    |                    | Florence S   | Stinson                |                  |              |           |   |
| 15. WAS DECEASED EVE                        | R IN U. S. ARMED FOR                              | CES? 16.   | SOCIAL SECURITY N  | O. 17. INF         | ORMANT The Me  | dical Rec              | ord Addre        | \$5          | 1         |   |
| No  | An Jon See and or order of t                      | ai vical   | scertainab         |                    | ne Clinical  |                        |                  |              | Mar       | yland                                       |
|   | ATH [Enter only one co                            |            |                    | :).]               |  |                        |                  |              | INTERV    | AND DEATH                                   |
| 6 6   | 202   |            |                    |                    |  |                        |                  |              |           |   |
| Day Barrier Description                     |   |            |                    |                    |  |                        |                  |              | months    |   |
| gove rise to i                              | mmediate  |            | r uespirat         | ery E              | xcursion   |                        |                  |              | Clas I    | MOITOILS                                    |
| couse (o), stoting<br>lying couse lost.     |   |            | Ad. 3 - 36 7       |                    |  |                        |                  | 2 - 4        | 15        | months                                      |
|   |   |            | tiple Myel         |                    | OT BELLTED TO THE TEN                                  |                        |                  |              |           |   |
| 3   |   | DILIONS C  | ONINBUING TO D     | EATH BUT N         | OT RELATED TO THE TERA                                 | WINAL DISEASE COI      | NOTTION GIVE     | N IN PART 1  |           | WAS AUTOPSY<br>PERFORMED?<br>ES <b>K</b> NO |
|   | AS UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC  | CRIBE HOW INJURY ( | OCCURRED.          | (Enter noture of injury in                             | Port I or Part II of   | item 18.)        |              |           |   |
| Y 20c. TIME OF INJUR<br>Hour o. m.<br>p. m. | Y Month, Doy, Yes                                 | While      | Not while of work  | 20e. PLAC<br>focto | E OF INJURY (Home, for<br>ry, street, office bldg., el | m, 20f. (City or to    | wn)              | (Co          | unty)     | (State                                      |
| alive on Sep                                |   | decease    | 59, and tha        | t death o          | , 19.59, to Securred at 1:45                           | AM, from the           | city or town, st | d an the     | st saw    | the decease<br>stated above<br>DATE SIGN    |
| SIGNATURE C                                 | name :  | - ' 4.     | 1 min              | M.                 |  | ical Cent              |                  |              | 9/4       | /59   |
| PHYSICIAN'S<br>NAME (Type)                  | CHARLES E.  | MENGE      | EL, M.D.           |                    |  | Institut               |                  | Healt        | h         |   |
| 220. BURIAL, CREMATIC<br>REMOVAL (Specify)  | SEPT. 6   | -59        | 22c. NAME OF CEA   | SEW                |  | 22d. LOCATION<br>RIG   |                  | county)      | HYD       | Brush VI                                    |
| 23. FUNERAL DIRECTOR                        | S SIGNATURE                                       | N          | ADDRESS            | ~D D               |  | D BY REGISTRAR         | 24b. REGIST      |              | 1.4       |   |
| W.W.C                                       | hamber  | - Co       | 1400 C             | broter             | STY DATE S   | SEP 8 '59              | Con              | thun &       | Thous     | 1   |

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|            |                                 | Moral City          |                   |              |
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10386

|  | m 2 FilmG249 9   | -28-59 et   | IE OF  | DUATIT   | Reg.        | Dist. No  |           |                  |
|--|--|---|--|--|-------------|-----------|-----------|------------------|
| PLACE OF DEATH G. COUNTY   |  | 2. USUAL RESIDENCE (  |  |  |             | sence bef | ore admi  | ssion)           |
| Montromery   | MARYLAND   | o. STATE Mary   | land   | b. COUNT   | Mor         | tgo       | mer       | T                |
| CITY OR TOWN [If outside corporate limits, write RURAL and give negrest town]  | c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (I  | f outside corp   | porate limits, write   |             |           |           |                  |
| RFD # 1, Silver Spr  | ing 3 yrs  | X /RFD/   | #/14/1   | 377 X 6 K/7  | 5001        | ng        |           |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in  | hospital, give street address)   | d. STREET ADDRESS   | Not  | given  | ,,,,        |           | e. IS R   | A FARM?          |
| Mt. Everest Care He  | ome  | M2//  |  | st/Care  | Hydn        | le        |           | NO               |
| NAME OF First DECEASED   | Middle   | Last  | 4. DATE  | Month  | -           | Day       | Y         | ear              |
| (Type or print) Danie:   | 1  | Ford  | OF<br>DEATH  | Sept   | . 22        |           | 1         | 9 59             |
|  | RRIED NEVER MARRIED  | 8. DATE OF BIRTH  |  | 9. AGE  In years   | IFUNDE      |           |           | ER 24 HRS.       |
| Male White wipo  | WED DIVORCED   | 8/30/72   | NAT.   | lost birthdoy)<br>87 yrs.  | Months      | Days      | Hours     | Min.             |
| a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | b. KIND OF BUSINESS OR INDUS   | STRY 11. BIRTHPLACE (State  | ar foreign c   |  | 12. CI      | TIZEN OF  | WHAT      | COUNTRY          |
| Laborer  |  | Virg  | inia   |  |             | US        | SA        |                  |
| FATHER'S NAME  |  | 14. MOTHER'S MAIDEN   |  |  |             |           |           |                  |
| unknown  |  | unkr  | nown   |  |             |           |           |                  |
|  | 16. SOCIAL SECURITY NO. 17.  | INFORMANT   |  | Address  |             |           |           |                  |
| No   | N  | t. Everest  | Care   | Home .   | Bilv        | er :      | Spri      | ing 1            |
| 18. CAUSE OF DEATH [Enter only one cause per li  |  |   |  |  |             | INTER     | VAL BETWE | EN               |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   | Coronary Occ   | lusion  |  |  |             | - 65.00   |           | de               |
| 420.1 DUE TO   |  |   |  |  |             |           | n be      |                  |
| Conditions, if any, which) (b)   |  |   |  |  |             | 1.1       | 1 00      | , u              |
| gove rise to immediate cause (a), stating the underlying DUE TO  |  |   | 1  |  |             |           |           |                  |
| couse last. (c)  |  |   | TO THE   |  |             |           |           |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS  | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERM   | INAL DISEASI   | CONDITION GIV  | EN IN PA    |           |           | AUTOPSY<br>RMED? |
| 20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESC  | RIBE HOW INJURY OCCURRED.  | (Enter nature of injury in Par  | t I or Port II   | of item 18.)   |             |           | r., []    | NO IAI           |
| PRIMARY ar CONTRIBUTING CAUSE OF DEATH.  |  |   |  |  |             |           |           |                  |
|  |  |   |  |  |             |           |           |                  |
|  | d. INJURY OCCURRED 20e. PL   | ACE OF INJURY (Home, form   | n, i 20f. (City  | or town)   | (C          | unty)     |           | (State)          |
| 20c. TIME OF INJURY Month, Day, Year 20 Hour o. m.   | /hile Not while foo  | ACE OF INJURY (Home, form<br>tory, street, affice bldg., etc.   | n, 20f. (City  | or town)   | (C          | iunty)    |           | (State)          |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 at  | /hite Not white for  | tory, street, affice bldg., etc   | )  |  |             |           |           |                  |
| 20c. TIME OF INJURY Month, Day, Year 20 W or m. 19 at 21. I certify that I taak charge af th   | /hile Not while foot wark at work eremains described about   | ave, held an Autaps   | y, lr  | spection 🔏   | Inqui       | гу 🔯,     | and       |                  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 at  | /hile Not while foot wark at work eremains described about   | ave, held an Autaps   | y, lr  |  | Inqui       | гу 🔯,     | and       |                  |
| 20c. TIME OF INJURY Month, Day, Year 20 W of Hour o. m. 19 of 21. I certify that I taak charge af the death resulted fram: Natural causes  | /hile Not while of work of wor | ave, held an Autaps   | y   , Ir   | spection 🔏   | Inqui       | гу 🔯,     | and o     | find tha         |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 w of 21. I certify that I taak charge af th death resulted fram: Natural causes   | /hile Not while foot wark at work eremains described about   | ave, held an Autaps sicide , Hamicide   | y   , Ir   | aspectian 🔼  | Inqui       | гу 🔯,     |           | find tha         |
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| 20c. TIME OF INJURY Month, Day, Year 20 Work Print Pri | /hile Not while of work of wor | ave, held an Autaps vicide , Hamicide  M.D. CHIEF MEDICAL EX ASSISTANT MEDIC DEPUTY MEDICAL               | y , Ir  CAMINER   AL EXAMINE  EXAMINER   CONTROL  TO THE CONTR | spection [], ndetermined c   | Inquiause [ | гу 🔯,     | DATE S    | Find tha         |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 of of the death resulted fram: Natural causes  ACTUAL SIGNATURE EXAMINER'S NAME (Type)  BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)  | /hile Not while of twork of or or work of twork of twork of two or   | ave, held an Autaps sicide, HamicideM.D. CHIEF MEDICAL E: ASSISTANT MEDIC DEPUTY MEDICAL R CREMATORY      | y , Ir<br>y , Ur<br>KAMINER  AL EXAMINE<br>EXAMINER  C   | aspection [X], andetermined co   | Inquiause [ | гу 🔯,     |           | Find tha         |
| 20c. TIME OF INJURY Month, Day, Year 20 Hour o. m. 19 of 21. I certify that I taak charge af the death resulted fram: Natural causes  ACTUAL SIGNATURE PRAIR SIGNATURE  EXAMINER'S NAME (Type)  BURIAL, CREMATION, 122b. DATE THEREOF  | /hile Not while of work of wor | ave, held an Autaps sicide , Hamicide  M.D. CHIEF MEDICAL ES ASSISTANT MEDICAL DEPUTY MEDICAL R CREMATORY | y , Ir<br>y , Ur<br>KAMINER  AL EXAMINE<br>EXAMINER  C   | aspection [X], and the state of | Inquiause [ | ry 🔼.     | DATE S    | Find tha         |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5M 9/55

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VS A1S (4) 15M 9/58 M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10427 CERTIFICATE OF DEATH

| )        | 1. PLACE OF DEATH  o. COUNTY  Montgomery   | MARYLAND            | 2. USUAL RESIDENCE (Who o. STATE  | ere deceased lived. If institu<br>b. COUNT |                  |                               |
|----------|--|---------------------|-----------------------------------|--|------------------|-------------------------------|
|          |  | ENGTH OF STAY IN 16 |                                   | utside corporate limits, write             |                  |                               |
|          | Bethesda   | 17 hrs.             | 26 Rockvil                        | le   |                  |                               |
| 1        | d. NAME OF HOSPITAL (If not in hospital, give street oddre OR INSTITUTION  | ss)                 | d. STREET ADDRESS                 |  | 72               | e. IS RESIDENCE<br>ON A FARM? |
| -        | Suburban   |                     | 733 Anders                        | on Ave.                                    |                  | YES NO                        |
|          | 3. NAME OF DECEASED (Type or print)  | Middle              | Last                              | OF   | onth Do          |                               |
|          | Minnie   |                     | Foster 8. DATE OF BIRTH           |  | ent. 2"          | 7 19 50                       |
|          | WIDOWED I  | J                   | 1- 1                              | last birthdoy)                             | Months Doys      | Hours Min.                    |
|          | Female White WIDOWED   | _                   |                                   | 1 09                                       |                  | WHAT COUNTRY?                 |
|          | during most of working life, even if retired)  | OI DOSINESS ON HADO | STATE TIL BIATTI BACE (STOTE )    | or foreign country;                        |                  |                               |
|          | Housewife Housewife  |                     | 14. MOTHER'S MAIDEN N             | oin is                                     |                  | J.S.A                         |
|          | 13. FATHER'S NAME  |                     |                                   |  |                  |                               |
|          | Samuel Lentz   |                     | Minni                             | ie, Adelaide I                             | ent Mat          | news                          |
|          | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCI   | AL SECURITY NO.     | NFORMANT                          | Ad   | dress            | 20 11-5 11                    |
|          | (Yes, ng or unknown) (If yes, give war or dates of service)  |                     | William                           | J. Foster.                                 | Gaither          | sburg Md                      |
|          | 18. CAUSE OF DEATH [Enter only one couse per line for  | (a) (b) and (a) 1   |                                   |  |                  | ERVAL BETWEEN                 |
|          |  |                     |                                   |  | ON               | SET AND DEATH                 |
| ed       |  | bral Thrombo        | osis                              |  | 1000             |                               |
|          |  |                     |                                   |  | The second       |                               |
| 4        | Conditions, if ony, which ) (b) Arter  | ioclosis            |                                   |  |                  |                               |
| 43       | gove rise to immediate couse (a), stating the under-   |                     |                                   | 21 5 4 311                                 |                  | Part of the P                 |
| Notifi   | lying couse lost.  | ular Tachyc         | ardia; Congest                    | ive Heart Fai                              | lure             |                               |
| 40       |  |                     |                                   |  |                  | 9. WAS AUTOPSY                |
| lar      |  |                     |                                   |  |                  | PERFORMED?                    |
| Brochart | PART II. OTHER SIGNIFICANT CONDITIONS CONTINUE  OR. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  PART II. OTHER SIGNIFICANT CONDITIONS CONTIL | HOW INJURY OCCURRE  | D. (Enter noture of injury in F   | Port I or Port II of item 18.)             | - 181 E          |                               |
| m        |  | OCCURRED 20e. PL    | ACE OF INJURY (Home, form,        | 20f (City or town)                         | (County)         | (Stote)                       |
|          | Hour a.m. While  | Not whilefo         | ctory, street, office bldg., etc. |  | (Coomy)          | (31016)                       |
| H        | p. m. 19 of work   | at work             |                                   |  |                  |                               |
|          | 21. I certify that I attended the deceased for   | ram sept a          | 26, 1959, ta -d                   | ent 27, 195                                | that I last say  | v the deceased                |
|          | alive an Sent 26 1959  | , and that death    | accurred at 5 40 A                | M. fram the causes a                       | nd an the date   | stated above.                 |
| П        | 1 1 7  |                     |                                   | ADDRESS (Street, city or town              |                  | DATE SIGNED                   |
|          | SIGNATURE Yames W. God   | 111                 |                                   |  |                  |                               |
| 1        | SIGNATURE / WITCH W  |                     | M.D. \                            |  |                  |                               |
| -        | PHYSICIAN'S James W. Egan  | 7720 Wisc           | onsin Ave. Be                     | thesda                                     |                  |                               |
|          | 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c.   | NAME OF CEMETERY O  | R CREMATORY                       | 22d. LOEATION ICINA town                   | or econty)       | (Stote)                       |
|          | REMOVAL (Specify) 9-29-59-7  | Haryelfer           | con,                              | The for                                    | 70,7             | Sozel                         |
|          | 23. EUNERAL DIRECTOR'S SIGNATURE   | ADDRESS             | 14a REC'I                         | D BY REGISTRAR 246. REG                    | ISTRAR'S SIGNATU | RE                            |
|          | 6 10 10 10 10 C  | 2:16                | 100/1                             | A A A 1EG                                  | other & Hear     |                               |
| 1        | mun & Jasmus   | anun                | burg DATE SE                      | 1 2 0 00                                   | AN 1864          | N/O                           |

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## CERTIFICATE OF DEATH

10388

Reg. Dist. No.

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may be retained by the haspital ar attending physician.

TO FUNERAL D. OR: After this certificate has been signed by the attending physician and campletely filled in b. funeral director, page 3 should a detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the registrar priar to burial, crematian, ar remaval, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

TO HOSPITAL OR VS A15 (4) 15M 10/57

| 1. PLACE OF DEATH o. COUNTY                               |   | MARYLAND                    | 2. USUAL RESIDENCE (W o. STATE Virgin                         | here deceased lived. If institution b. COUNTY | Residence before admission) Fairfax                |
|---|---|-----------------------------|---|---|--|
| b. CITY OR TOWN (I  | gomery f outside corporate limits, write                        | c. LENGTH OF STAY IN 16     | -   | outside corporate limits, write RU            |  |
| Bethesda  | earest town)  | 6 days                      | Falls Chur  |   | 3×-3   |
| d. NAME OF HOSPIT.  | AL (If not in hospital, give street                             |                             | d. STREET ADDRESS   | 011   | e. IS RESIDENCE                                    |
| OR INSTITUTION  | al Center. Bet  |                             | 1932 Storm  | Drive   | ON A FARM? YES NO DO                               |
| 3. NAME OF  | First   | Middle                      | Last  | 4. DATE Month                                 |  |
| (Type or print)   | Larry   | Edman                       | Freeman   | OF September                                  | 4 -  |
| S. SEX  | 6. COLOR OR RACE 7. MAR   | RRIED NEVER MARRIED         | B. DATE OF BIRTH  | 9. AGE (In years I                            | FUNDER I YEAR IF UNDER 24 HRS.                     |
| Male  | White WIDOW   | VED DIVORCED                | November 25.  | 1941 17 yrs.                                  | Months Doys Hours Min.                             |
| 10a. USUAL OCCUPATIO                                      | ON (Give kind of work done 10b                                  | . KIND OF BUSINESS OR INDU  |   |   | 12. CITIZEN OF WHAT COUNTRY                        |
| Meat Clerk  |   | Meat Markets                | North Car   | olina   | U. S. A.   |
| 13. FATHER'S NAME   |   | + MEET AT LEEU              | 14. MOTHER'S MAIDEN   | NAME  |  |
| John C. Fr  | reeman. Sr.   |                             | Edith Barn  | ies   |  |
|   | R IN U. S. ARMED FORCES? 16                                     | SOCIAL SECURITY NO. 17. 1   | NFORMANT The Med  | ical Record Addres                            | is   |
| No  |   | 39-64-4934 T                | he Clinical C   | enter, Bethesda                               | 14, Maryland                                       |
|   | TH [Enter only one couse per I                                  | ine for (o), (b), and (c).] |   |   | INTERVAL BETWEEN                                   |
| PART I. DEA   | TH WAS CAUSED BY: IMMEDIATE CAUSE (o) PC                        | ost-operative C             | ardiac Failur   | re  | 24 hours   |
| 754,5   | DUE TO  |                             |   |   |  |
| Conditions, if or   | ny, which ) (b) To  | tal Anomalous               | Pulmonary Ver   | ous Return                                    | Birth  |
| gave rise to in<br>couse (a), stating t                   |   |                             |   |   |  |
| lying couse lost.   |   | rial Septal De              |   |   | Birth  |
| PART II. OTH  | IER SIGNIFICANT CONDITIONS                                      | CONTRIBUTING TO DEATH BUT   | NOT RELATED TO THE TERM                                       | INAL DISEASE CONDITION GIVE                   | N IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES X NO |
| 200. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | S UNDERLYING [] 206. DES<br>CAUSE OF DEATH<br>MEDICAL EXAMINER) | SCRIBE HOW INJURY OCCURRE   | D. (Enter noture of injury in                                 | Port I or Part II of item 1B.)                |  |
| Y 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.              | While   |                             | ACE OF INJURY (Home, forn<br>ctory, street, office bldg., etc | n, 20f. (City or town)                        | (County) (State)                                   |
| 21. I certify the   | at I attended the decea   | sed from September          | r 6, 19 59, to Se   | ptember 1219 59                               | that I last saw the decease                        |
| alive an Sept   | tember 12 , 19  | 59, and that death          | accurred at 11:15   | AM, from the causes an                        | d an the date stated above                         |
|   | 11/   | 1 '                         |   | ADDRESS (Street, city or town, st             |  |
| ACTUAL<br>SIGNATURE                                       | - Sent/ar   | my 100                      | M.D. The Clini  | cal Center                                    | 9/12/59  |
|   | E. KENT CARNEY  | M.D.                        |   | Institutes of h                               | [ealth   |
| BURIAL CREMATION REMOVAL TOPECIFY) DULLE TURNS            | 22b. DATE/THEREOF   | 22c. NAME OF CEMETERY O     | R CREMATORY   | 22d. LOCATION (City, town, or                 | (Stote)  |
| 23. FULLERAL DIRECTOR'S                                   | SIGNATURE   | ADDRESS                     | 2409 REC  | D BY REGISTRAR 246. REGIST                    | RAR'S SIGNATURE                                    |

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10429 CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence befare admission) a. STATE // b. COUNTY . |
|--|---|
| MONTGOMETY MARYLAND  | Maryland Montgomery   |
| b. CITY OR TOWN (It outside carporate limits, write RURAL and give regrest town)   | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)                              |
| Chery Chase  | X Chevy Chase   |
| d. NAME OF HOSPITAL (It not in haspital, give street address) OR INSTITUTION   | d. STREET ADDRESS e. IS RESIDENCE   |
| 2802 Washington Ave. Ch. Ch. Md.   | 2802 Wash. Ave. ON A FARM? YES NO IN  |
| 3. NAME OF DECEASED (Type or print) Morrs 5  | Friedmon 4. DATE Month Day Year OF DEATH September 28 1959  |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   |   |
| Male White WIDOWED DIVORCED  | Abr. 15, 1893 last birthday) Manths Days Haurs Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDI  |   |
| doring most dr working fire, even ir retired)  | D   |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
| 1200h Friedman   | F. C. D. I. I.  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.   | LY4 DeDCHIA   |
| [Yos, no, or unknown] (If yes, give wor or dates of service)   | INFORMANT Address Ch.   |
| NO UNKNOWN M   | rs. Mannah Priedman - 1802 Wash. Hve. M   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | INTERVAL BETWEEN  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chance can  | resture heart la tuo ONSET AND DEATH  |
| 420.1 DUE TO   | family 1 speak  |
| Conditions, if ony, which ) ( Cononary this  | inferred to use did to  |
| gave rise to immediate   | my comments allow is the only   |
| cause (a), stating the under-  |   |
| lying cause last. (c)  | ivery displayed 10 year   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU   | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?                 |
| 3 De afeld mellaling.  | YES NO NO   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER) | ED. (Enter nature af injury in Part I ar Part II of item 18.)   |
|  |   |
|  | LACE OF INJURY (Home, form. 20f. (City or tawn) (County) (State)  |
| While Nat white at wark at work  | , and orag, orac  |
| 21. I certify that I attended the deceased from  | Just 1057 4 XOR+ 120 1054   |
| 1 4 1  | 1956, to 1957, that I last saw the decease  |
| alive an, and that death   | h occurred at 945 A.M., from the causes and on the date stated above  |
| ACTUAL SUCTO STATE OF STATE OF   | ADDRESS (Street, city or town, state)  DATE SIGNE   |
| SIGNATURE SIGNATURE SIGNATURE SIGNATURE  | M.D. 70 Colofolishof Sheld Miss ma, 728   |
| PHYSICIAN'S Sydney Leventhal   |   |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF BUT Sholom   | OR CREMATORY 22d. LOCATION (City, town, or county) (State) HIIISIAE, Md.,                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | A A COAL BECID BY DECISTORS ON DECISTORS CICALITIES   |
| B. Danzansky& Sons 3501-14thSt.N.W.  | (V(a))),DC 1 150  |
|  | DATE DOS Orthur & H.  |

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| and 2 shauld be filed | 05 | -/ |

| 5.5 TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page |         | 🛬 TO FUNERAL Discretificate has been signed by the attending physician and campletely filled in by the funeral directa | - SE WI | 1   |
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| death.  |         | neral  | d be fi |   |
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| d with  |         | oletely  | rs. Po  |   |
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| tificat   |         | physici  | maye o  | hours   |
| oth cer   |         | ding !   | ase re  | in 72   |
| he dec  |         | e atter  | en ple  | Tiw to  |
| that t  |         | by the   | it. Th  | ny ever   |
| quires  | _       | igned  | perm    | d in ar   |
| law re  | ysician | been   | -transi | al, and   |
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| PHY!  | tal ar  | this ce  | ar use  | remati  |
| DING  | haspi   | After  | ched fo | the registrar priar to burial, cremation, ar remayal, and in any event within 72 havrs after death. |
| ATTER   | y the   | TOR  | e detac | r ta bu   |
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10391 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. 215

| 10431 CERTIFICATE OF DEATH |  |
|----------------------------|--|
|----------------------------|--|

| 1. PLACE OF DEATH o. COUNTY  |                           | 2. USUAL RESIDENCE (W          |                                       | If institution: Resider | nce before admiss | ian)           |
|--|---------------------------|--------------------------------|---------------------------------------|-------------------------|-------------------|----------------|
| Montgomery   | MARYLAND                  | West Vir                       |                                       |                         |                   |                |
| CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  | c. LENGTH OF STAY IN 16   | c. CITY OR TOWN (IF            | outside corporate lin                 | nits, write RURAL and   | give nearest town | )              |
| Bethesda (Rural)   | 4 days                    | Elkins                         |                                       | 85 x -                  | 3                 |                |
| d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION  | oddress)                  | d. STREET ADDRESS              |                                       |                         | e. IS RES         | DENCE<br>FARM? |
| U. S. Naval Hospital   |                           | Box 183.                       | Parsons                               | Road                    |                   | МОД            |
| 3. NAME OF First   | Middle                    | Lost                           | 4. DATE                               | Month                   | Day '             | rear .         |
| (Type or print) Charles  | Willard                   | GEYER                          | OF<br>DEATH                           | Septembe                | er 12             | 1959           |
| 5. SEX 6. COLOR OR RACE 7. MARI  | RIED NEVER MARRIED        | 8. DATE OF BIRTH               | 9. AG                                 |                         | TYEAR IF UNDE     |                |
| Male Caucasian widow   | ED DIVORCED               | 6-8-14                         | 4                                     | birthday) Months        | Days Hours        | Min.           |
| 10a. USUAL OCCUPATION (Give kind af wark dane 10b. during mast of working life, even if retired)   | KIND OF BUSINESS OR INDU  | STRY 11. BIRTHPLACE (State     | e or foreign country)                 | 12. CIT                 | IZEN OF WHAT C    | OUNTRY?        |
| State Engineer   | State                     | Wiscons                        | sin                                   | U.                      | S.A.              |                |
| 13. FATHER'S NAME  |                           | 14. MOTHER'S MAIDEN            | NAME                                  |                         |                   |                |
| Charles William GEYER  | 3                         | Mary A.                        | WOLF                                  |                         |                   |                |
|  | SOCIAL SECURITY NO.       | NFORMANT                       | TE                                    | Address                 | 1                 |                |
| Yes, no, or ynknown) (If yes, give war ar dates of service)  | Н                         | ospital Red                    | cords                                 |                         |                   |                |
| 18. CAUSE OF DEATH [Enter only one couse per ]   | 77                        | 1                              | 1/                                    |                         | INTERVAL BE       |                |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   | onelines                  | Kdr cas                        | Vane                                  | 11                      | ONSET AND         | DEATH          |
| 2043 DUE TO  | A A                       | The many                       | 77                                    | 111                     |                   |                |
| Canditians, if ony, which )  | 0.4                       | 7                              | Tio 1                                 | 1. 800-                 |                   |                |
| gave rise to immediate   | man o                     | Tympha                         | The of                                | M KUN                   |                   |                |
| lying cause last   |                           | 0 ()                           |                                       |                         | 1390              |                |
| , (c)  | CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERM        | MINAL DISEASE CON                     | DITION GIVEN IN PA      | RT 1(a) 19. WAS / | AUTOPSY        |
| DITA   |                           |                                |                                       |                         | PERFO             | RMED?          |
| PART II. OTHER SIGNIFICANT CONDITIONS    200. ACCIDENT WAS UNDERLYING   20b. DES   OR CONTRIBUTING   CAUSE OF DEATH   (IF EITHER, NOTIFY MEDICAL EXAMINER) | CRIBE HOW INJURY OCCURRE  | D. (Enter nature of injury in  | Part I ar Port II of i                | tem 1B.)                | 100               |                |
| OR CONTRIBUTING CAUSE OF DEATH   |                           |                                |                                       |                         |                   |                |
| S 20c. TIME OF INJURY Month, Day, Year 20d, I  |                           | ACE OF INJURY (Home, for       |                                       | vn)                     | (County)          | (State)        |
| Y 20c. TIME OF INJURY Month, Day, Year 20d. I While p. m. 19 at war  |                           | ctary, street, affice bldg., e | tc.)                                  |                         |                   |                |
|  |                           | 9 10 50 1                      | 0004 30                               | 150 11 111              |                   |                |
| 21. I certify that I attended the decease  |                           |                                |                                       |                         |                   |                |
| alive an Sept. 12 , 19   | 29, and that death        | accurred a 10:4!               | 2™, fram the c<br>ADDRESS (Street, ci |                         |                   | abave.         |
| ACTUAL / 10/13 O   | (20 Va.                   | II G                           |                                       |                         | 0 13              | 50             |
| SIGNATURE  | Jaken                     | M.D. U.S.                      | Naval H                               | ospital                 | 9-13              | -29_           |
| PHYSICIAN'S William P. BAK   | FR IT MC                  | USN Bethe                      | sda, Md.                              |                         |                   |                |
|  |                           |                                |                                       |                         |                   |                |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF<br>Burial-Shipment 9-14-59   | 22c. NAME OF CEMETERY C   | R CREMATORY                    |                                       | City, town, or county)  | (State            |                |
| *  | 1                         | D 0 10 200                     | Elk                                   |                         |                   | inia           |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |                           |                                | C'D BY REGISTRAR                      | 24b. REGISTRAR'S S      | GNATURE           |                |
| W.W.Chambers & Co., 1400   | J. ChapinsT.,             | NW DATE                        | EP 1 6 '59                            | Orthur J                | Kana              |                |

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 CERTIFICATE OF DEATH 10432 Reg. Dist. No. directar, iled with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY Montgomery MARYLAND Maryland Montgomery uneral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) RURAL ond give nearest town) Kensington Kensington d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Gretchen Street 5208 Gretchen Street NAME OF First Middle 4. DATE Lost DECEASED DEATH Sept. 13,1959 (Type or print) ELIZABETH VERONICA GILLESPIE 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthdoy) Female White WIDOWED X DIVORCED [ Nov. 0 papers. 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Ireland Housewife Own Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Thomas Kline O'Toole 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Thomas Gillespie-Item# No 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** couse (a), stating the underlying couse lost. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a. m. Not while

of work

22c. NAME OF CEMETERY OR CREMATORY

Calvert

**ADDRESS** 

E. Montgomery Rockville, Md

of work

21. I certify that I attended the deceased fram.

e. IS RESIDENCE ON A FARM? YES NO TH Year 19 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Hours Min. 12. CITIZEN OF WHAT COUNTRY? INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES M NO (County) (Stote) to SEPT 13, 1959, that I last saw the deceased and that death occurred at 11:05 PM, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED 22d. LOCATION (City, town, or county) (Stote) eveland. Ohio 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR SEP 1 8 '59

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15M 9/55

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FUNER

**ACTUAL** SIGNATURE

PHYSICIAN'S NAME (Type)

Bur-Trans

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

220. BURIAL, CREMATION, 226. DATE THEREOF

Page

death.

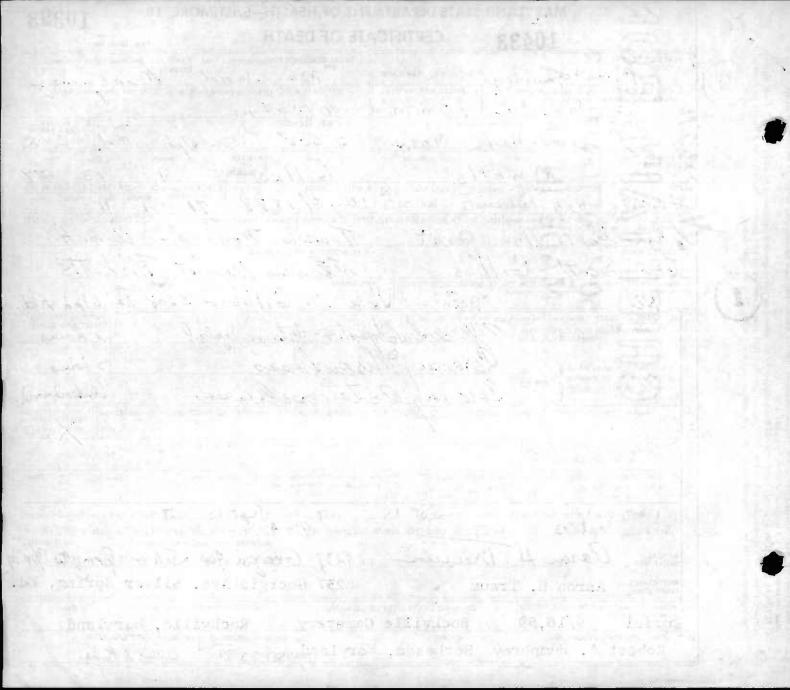
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|               |  |  |       |                       |
|               |  |  |       |                       |
|               | HIND SELL I T STORMAN  | must run tec   |       | A real virtue (First) |
|               |  |  |       | 27/9/02/              |
|               |  | A CHARLETT AND THE AND |       | ~ ~                   |
|               |  |  |       |                       |

Rea. Dist. No.

|         | 20100  |  |
|---------|--|--|
| 1.      | PLACE OF DEATH  a. COUNTY  MARYLAND  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE  a. Tand. COUNTY  a. Tand. COUNTY   |
|         | b. CITY OR TOWN (If autside corporate limits, with c. LENGTH OF STAY IN 1b RURAL and give nearest town)  | c. CITY OR TOWN (If cutside carporate limits, write RURAL and give pearest town)   |
| -       | d. NAME OF HOSPITAL (If nat in haspital, give street address)  OR INSTITUTION  | d. STREET ADDRESS  o. IS RESIDENCE ON A FARM?  |
| -       | Juburban Hospi   | 3 608 / andolph Rd YES NOR   |
| 3.      | NAME OF DECEASED (Type or print)  First Middle  Y n + / E  | Lost 4. DATE Month Day Year OF DEATH 9 13 1959   |
| 5.      | SEX  6. COLOR OR RACE (7. MARRIED   NEVER MARRIED   DIVORCED   | 8. DATE OF BIRTH  Clug 2/1888  9. AGE (In years last birthday)  7/ yrs.    Hounder 1 YEAR IF UNDER 24 HRS.   Months Days Haurs Min.   Months Days Min.   Months Days Min.   Months Days Min.   Month |
| 10      | during most of working life, even if retired)  Lurk - Lout Office Rind of work dane 10b. KIND OF BUSINESS OR INDICATED TO THE COLUMN CO | USTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?   |
|         | John Scott Gilliss   | 14. MOTHER'S MAIDEN NAME LEGanna Harriet Ricketts INFORMANT Address  |
|         | (es, no, or unknown) (If yes, give wor or dates of service)  | icla L. Gilliss - 5608 Randolph Rd   |
|         | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO   | Apretion - Anterior Septal Interval BETWEEN ONSET AND DEATH  |
|         | Canditions, if any, which gave rise to immediate DUSTO   | Terembosis 2 hours   |
| -       | lying cause last. (c) Coronary Co  | sterioselerosis Unknown  |
| CATION  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU   | IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PREFORMED?  YES NO   |
| CERTIFI | 20g. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRI<br>OR CONTRIBUTING   CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | ED. (Enter nature of injury in Part I ar Part II af item 18.)  |
| MEDICAL | 20c. TIME OF INJURY Manth, Day, Year Haur a. m. 19 While at wark at wark 19  | CLACE OF INJURY (Hame, farm, actory, street, affice bldg., etc.) (City or tawn) (Caunty) (State)   |
|         | 21. I certify that I attended the deceased fram Sept 13 alive an Sept 13 , 1957 , and that deat  | h accurred at 4:0 AM, from the causes and an the date stated abave.  ADDRESS (Street, city or town, state)  DATE SIGNED  |
|         | ACTUAL SIGNATURE ROSEN H. Maum   | M.D. 8237 Georgia Ave Silver Springly 9/14-  |
|         | PHYSICIAN'S NAME (Type) Aaron H. Traum   | 8237 Georgia Ave. Silver Spring, Md  |
| 22      | Removal (Specify) 9/16,59 Rockville  |  |
| 23      | FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | Maryland ATESEP 1 5 '59  ROCKVIIIE MAT VIATIO  240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  ATELIAN ATELIAN   |
| -       |  |  |

Y the haspital ar attending physician.

JOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, detached far use as the burial-transit permit. Then place from ye carbon popers. Pages 1 and 2 shauld be filed with the hurial cremation, ar remayol, and in any event within 72 haurs after death. er death. Page 4 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs page 3 shauld be detached far use as the burial-transit permit. Then plear the registrar prior to burial, cremation, ar remavol, and in any event within



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| MEDICAL EXAMINER   | S CERTIFICATE OF DEATH  Reg. Dist. No.   |  |  |  |  |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)  |  |  |  |  |
| b. CITY OR TOWN (If outside corporal limits, write RURAL c. LENGTH OF STAY IN 16 and give necres) town)  | c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If hat in hospital, give street address),  | d. STREET ADDRESS  o. IS RESIDENCE ON A FARM? YES NO   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) adelaide C   | GLEGAON 4. DATE Month Day Year OF DEATH DEATH 25 1959  |  |  |  |  |
| Secure white WIDOWED   DIVORCED  | 8. DATE OF BIRTH  12-31-1883  9. AGE (In yells lost birthday)  7.5 yrs.  IFUNDER TYEAR IF UNDER 24 HRS  Months Days Haurs Min.   |  |  |  |  |
| 100, USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR INDUSTRIES OF I | D.C. 21-8.C.   |  |  |  |  |
| 13. FATHER'S NAME  | adelaide Brown   |  |  |  |  |
| 15. Wals DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) (It yes, give wor or dates of service)  NO  17.  | M. A. Gleason - Itu >  |  |  |  |  |
| PART I. DEATH (Enter only one cause per line far (a), (b), and (c).  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  | istiva heart desense Sudden  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause   | 2 day  |  |  |  |  |
| (a), stating the underlying DUE TO   |  |  |  |  |  |
| CATIO  | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO   |  |  |  |  |
|  | (Enter nature of injury in Part I ar Part II of item 18.)  ACE OF INJURY (Hame, farm, 120f. (City or town) (County) (State)  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Haur a, m. 19 20d. INJURY OCCURRED While Nat while at work at wor |  |  |  |  |  |
| 21. I certify that I toak charge of the remains described ab death resulted from: Natural causes X, Accident , Su  |  |  |  |  |  |
| SIGNATURE Frank J. Brischart   | M.D. CHIEF MEDICAL EXAMINER DATE SIGNED  |  |  |  |  |
| EXAMINER'S FLADK J. Brosehent  | ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEP |  |  |  |  |
| 226. BURIAL, CREMATION. PERMOYAL (Specify) 9/29/59 Glenwood C  | emetery Washington, D.C.   |  |  |  |  |
| 23. SUMERAL DIRECTOR'S GIGNATURE 2901 14 APPRESS t. N. Washing ton 9.D. C.   |  |  |  |  |  |

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The hospital or ottending physicion.

FUNERAL L.

Standid (1) Jetached for use as the buriol-transit permit. Then please remayescarbon papers. Pages 1 and 2 snould be the registrar prior (5) buriol, cremation, or removal, and in any event within 72 hours offer death. TO HOSPIT... TO HOSPIT... And Joyne To FunerAL L. 120 10/21

death: Page 4

funerol director,

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

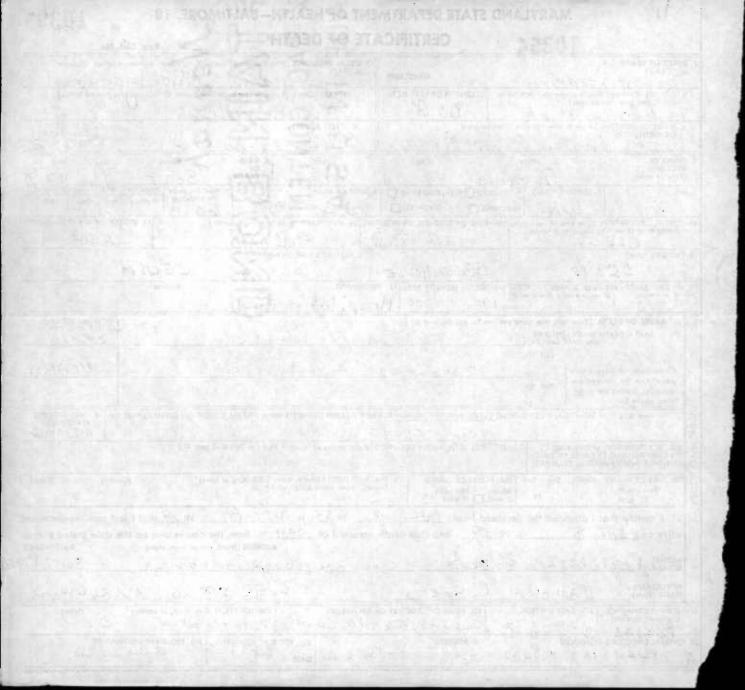
10395

10354

**CERTIFICATE OF DEATH** 

Reg. Dist. No.

| 1, 1          | PLACE OF DEATH<br>D. COUNTY  |                            | 2. USUAL RESIDENCE (Where deceased           | lived. If institution: Resider | nce before admission)  |
|---------------|--|----------------------------|--|--------------------------------|------------------------|
| 1             | montamery  | MARYLAND                   | o. STATE                                     | P. COUNTY                      | omeru 6.               |
|               | b. CITY OR TOWN (If outside corporate limits, write  | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (If outside corpo            |                                |                        |
| ~             | BURAL and give nearest town  | DOA                        | 7/40 Havi                                    | 110                            | 11/15 3                |
| -             | d. NAME OF HOSPITAL (If not in haspital, give street   |                            | d. STREET ADDRESS                            | 116                            | e. IS RESIDENCE        |
|               | OR INSTITUTION   | -111                       | (1212 - 11/+1                                | 1                              | ON A FARM?             |
| _             | Washington Jan   | MOSP.                      | 1 8 313 - 14 th                              | , are.                         | YES NO                 |
| 3.            | NAME OF First  | Middle                     | Lost 4. DATE                                 | Manth                          | Day Year               |
|               | (Type or print) Samu   | el                         | Green DEATH                                  | Sept                           | 8 1959                 |
| 5. 3          | SEX 6. COLOR OR RACE 7. MARR   | IED NEVER MARRIED          | B. DATE OF BIRTH                             |                                | TYEAR IF UNDER 24 HRS. |
|               | m. Wh. WIDOWE  | DIVORCED                   | 12-23-98                                     | 6 D yrs.                       | Days Hours Min.        |
| 10a           | . USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)                      | KIND OF BUSINESS OR INDI   | STRY 11. BIRTHPLACE (State or foreign co     | ountry) 12. CII                | TIZEN OF WHAT COUNTRY? |
|               | CLERK  | RETAIL - STOR              |  |                                | U.S.A.                 |
| 13.           | FATHER'S NAME  | 3101                       | 14. MOTHER'S MAIDEN NAME                     | ,                              |                        |
|               | LANIS  | GREENHOUSE                 | ANNA   | OGUSE                          | 4                      |
|               |  | SOCIAL SECURITY NO. 17.    | INFORMANT                                    | Address                        |                        |
| 110           | (If yes, give war or dates of service)   | 72284682-H                 | ospital records                              | 5                              |                        |
|               | 18. CAUSE OF DEATH [Enter only one couse per lin   | ne for (o), (b), ond (c).] |  | *                              | INTERVAL BETWEEN       |
|               | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)   | CORON                      | ARU OCCLUSIO                                 | 201                            | ONSET AND DEATH        |
|               | 420.1 DUE TO   |                            | - Y  |                                |                        |
|               | Conditions, if any, which )  | CORONARU                   | ATHEROSCLER                                  | 2220                           | 240ABS.                |
|               | gove rise to immediate   | COMONTINE                  | 77111210302072                               | .03 ( 3                        | - 6613(53)             |
|               | couse (o), stoting the <u>under:</u> DUE TO  lying couse lost.   |                            |  |                                |                        |
| Z             |  | CALIFORNIA TO DESTRUCTO    |  |                                |                        |
| 2             | PART II. OTHER SIGNIFICANT CONDITIONS C  | ONIKIBUTING TO DEATH BU    | NOT RELATED TO THE TERMINAL DISEAS           | E CONDITION GIVEN IN PAR       | PERFORMED?             |
| ₹.            | f  | thy FEVE                   | R  |                                | YES NO P               |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. DESC<br>OR CONTRIBUTING 2 CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | CRIBE HOW INJURY OCCURRI   | D. (Enter nature of injury in Port I or Port | I II of item 18.)              |                        |
| A             | 20c. TIME OF INJURY Month, Day, Year 20d. IN   | JURY OCCURRED 20e. PI      | ACE OF INJURY (Home, form, 20f. (City        | or town)                       | County) (State)        |
| MEDICAL       | Hour a.m. 10 While   | Nat while fa               | ctary, street, office bldg., etc.)           |                                | county) (sidile)       |
| Z             | p. m. 19 of worl   |                            |  |                                |                        |
|               | 21. I certify that I attended the decease  | ed fram DEC. 19            | 9 , 1953, to SEPT 8                          | 19.59,that I                   | last saw the deceased  |
| 1             | alive an SEPT 8 19   | 59, and that death         | accurred at 500 M, from                      | the causes and on t            | he date stated abave.  |
|               |  | 1'                         |  | reet, city or town, state)     | DATE SIGNED            |
|               | SIGNATURE Jamesa, Ro   | herte                      | M.D. 8907 GEORGH                             | ARVENIE                        | SEPT 9. 19             |
|               | SIGNATURE  |                            | M.D  | MINIOR                         |                        |
|               | PHYSICIAN'S NAME (Type) JAMES A.   | ROBERTS                    | SILVER                                       | 5 ARINGS M                     | ARYLAND.               |
| 220           | BURIAL, CREMATION, 22b. DATE THEREOF   | 22c. NAME OF CEMETERY C    |  | TION (City, town, or county)   | (Stote)                |
|               | BURIAL 9-9-59  | ELESAVETG                  |  | HINGTON                        | 0.0.                   |
| 23.           | FUNERAL DIRECTOR'S SIGNATURE   | ADDRESS                    | 24a. REC'D BY REGIST                         | RAR 24b. REGISTRAR'S SI        | GNATURE                |
| B             | ". DANZANSKY + SONS -  | -35-01-144                 | St. N. W. DATE SEP 11                        | '59 anthun                     | S. Krus                |
|               |  |                            | PAIL   |                                |                        |



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## TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician. O FUNERAL D: OR: After this certificate has been signed by the attending physician and campletely filled in by funeral page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be the registrar prior to burial, crematian, ar remaval, and in any event within 72 haurs after death. may be relained TO FUNERAL DI

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10436 CERTIFICATE OF DEATH

10397

Reg. Dist. No.

|   | Neg. Dist  | . 110.                                  |
|---|--|---|
| 1. PLACE OF DEATH O. COUNTY  MO NIDOMERY  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence o. STATE b. COUNTY b. COUNTY   | e before admission)                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | c. CITY OR TOWN (If outside corporate limits, write RURAL and gi   | ve nearest town)                        |
| GERMANTOWN / MONTH  | 2103-  | 1                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION MALY LANDEY REST HOME  | d. STREET ADDRESS  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF DECEASED (Type or print) Robert PAUL GLO   | Lost 4. DATE Month OF DEATH  | Doy Year 20 1957                        |
| 700-61  |  | YEAR IF UNDER 24 HRS.                   |
| MALE WHITE WIDOWED DIVORCED   | 2-18-1902 last birthdoy) Months 1  | Days Hours Min.                         |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Restura  | STRY 11. BIRTHPLACE (State or foreign country)  High Howse PA  | ZEN OF WHAT COUNTRY?                    |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 1  | INFORMANT Address  |   |
| (Yes, no. or unknown) [If yes, give wor or dates of service)  | Vivian Grad Ge   | Mach 100                                |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  OTHERS  WAS CAUSED BY: IMMEDIATE CAUSE (o) | rembosis   | INTERVAL BETWEEN ONSET AND DEATH        |
| Conditions, if ony, which) bullivische C  | indivoscula diseire  | 3 years                                 |
| gove rise to immediate couse (a), stating the under-lying couse last.   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT   | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART  | 1(o) 19. WAS AUTOPSY PERFORMED? YES NO  |
| 20g. ACCIDENT WAS UNDERLYING [] CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | D. (Enter nature of injury in Port I or Port II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED to Mour o. m. While Not while of work of work of work   | ACE OF INJURY (Home, form, ctory, street, office bldg., etc.)  | ounty) (Stote)                          |
| 21. I certify that I attended the deceased from Jept 5  | , 1959, to Jank 70, 1959, that I lo  | ast saw the deceased                    |
| alive an option, 1974, and that death   | occurred atM, from the causes and an th  | e date stated above.                    |
| ACTUAL SIGNATURE SIGNATURE  | M.D. Domasey, Ma   | DATE SIGNED                             |
| PHYSICIAN'S James P. Kerr   | /  |   |
| inchal 1  | CREMATORY 22d LOCATION (City town, or county)  Liver ferroles up to file f   | (Stote)                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MINUS  | LANGE DATE CED 2 2 159 Colons A  |   |
| 1 per so  | To the state of th | ALCOHOL:                                |

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| Street Total |                                 |
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15M 9/55

| ARTMENT OF HEALTH-BALTHMORE, 18  | THE STATE CHARYLAND STATE DEP  |
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5M 9/55

| 4.0  | MEDICA                                      | L EXAMINER'S   | CERTIFICAT   | E OF DEATH                                | 10399<br>Reg. Dist. No.  |
|--|---|--|--|---|--|
| 1. PLACE OF DEATH O. COUNTY Monta  | omery                                       | MARYLAND   | 2. USUAL RESIDENCE (W  | here deceased lived. If instit<br>b. COUN | tution: Residence before admission)  TY Montgorner   |
| b. CITY OR TOWN (If outside careforal and give nearest town)   | e limits, write RURAL                       | c. LENGTH OF STAY IN 16                                    | c. CITY OR TOWN (IF  | Spring                                    | e RURAL and give(nearest town)   |
| d. NAME OF HOSPITAL OR INSTIT  | FUTION (If not in hos                       | pital, give street address)                                | d. STREET ADDRESS  | Quebec ?                                  | Terrace YES NO   |
| 3. NAME OF DECEASED (Type or print)  | First                                       | E . Har  | nstead   | 4. DATE Mon OF DEATH                      | th Day Year — 14 195   |
| 5. SEX 6. COLOR 6. WA  | OR RACE 7. MARRIE                           |  | DATE OF 81RTH 2-10-18  | 9. AGE (In years lost birthday) Go 7 yrs. | Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind during most of working life, even in the control of the control |   | IND OF BUSINESS OR INDUSTR<br>Itgomery High S              |  | vest va.                                  | 12. CITIZEN OF WHAT COUNTE   |
| 13. FATHER'S NAME  | SEYMOUR                                     | Hamstend   | 14. MOTHER'S MAIDEN NA<br>Mati                                   | ame<br>Ida Fik                            | * p.25   |
| 15. WAS DECEASED EVER IN U. S. A (If yes, give wor   |   | SOCIAL SECURITY NO. 17. IN 234-28-7068                     | PORMANT<br>1ervin H  | . Hamstoad                                | 8703 Gilbert F   |
| 18. CAUSE OF DEATH [Enter on PART I. DEATH WAS CAU IMMEDIATE (Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying couse fost.   | SED BY: CAUSE (o)  DUE TO  (b)  DUE TO  (c) | ormany !   | icclusio   |   | INTERVAL BÉTWÉEN 1 CONSET AND DEATH  |
| PART II, OTHER SIGNIFICATION OF THE PRIMARY OF DEATH.  | 1 delin                                     | NTRIBUTING TO DEATH BUT NO PLEASE HOW INJURY OCCURRED. (EA | deseas   |   | IVEN IN PART 1(a)  19. WAS AUTOPS: PERFORMED? YES \( \begin{array}{ccc} NO \( \beta \) \end{array} |
| 20c. TIME OF INJURY Month,<br>Hour a. m.<br>p. m.  | While                                       | NJURY OCCURRED 200, PLAC                                   | E OF INJURY (Home, farm, ry, street, office bldg., etc.)         | 20f. (City or town)                       | (County) (Stote)   |
| 21. I certify that I tack death resulted from: N  ACTUAL SIGNATURE JACK  |   |  | e, held an Autopsy<br>ide [], Homicide<br>M.D. CHIEF MEDICAL EXA | , Undetermined                            | Inquiry X, ond find th cause   |
| EXAMINER'S FAAN  220. BURIAL, CREMATION, 22b. DAT  |   | hoschart<br>22c. NAME OF CEMETERY OR C                     | DEPUTY MEDICAL EX  | XAMINER A                                 | 9-14-59  |
| BURIAL (Specify) 9/17  | 7/59  | GEO. WASH. GEME  | TERY   |   | COUNTY, MARYLAND   |
| Caymoud A.Z.   | ey, inc.                                    | SILVER SPRING  | MD   |   | Albur & Kraus  |

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10400 Rea. Dist. No

|  | 1043   | 8 -  | CERTIFIC   | ATE OF DEATH  | Reg. I  | Dist. No.  |
|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery   |  | STATE OF   | MARYLAND   | 2. USUAL RESIDENCE (Who o VITE inia   | ere deceased lived. If institution: Resid<br>b. COUNTY  | lence befare admission)  |
| b. CITY OR TOWN (If<br>RURAL and give ne   | autside carporate limits, w  | rite c. LENC   | OTH OF STAY IN 16  | c. CITY OR TOWN (If or  | utside corporate limits, write RURAL and  | d give nearest town)   |
| Bethesda   | (Rural)  |  | 95 hours   | Marrifield  | 83 X-   | 3  |
| d. NAME OF HOSPITA   | AL (If not in hospital, give s   | street oddress)  |  | d. STREET ADDRESS   |   | e. IS RESIDENCE  |
| U.S. Nava  | l Hospita 1.   | Bethes   | da 14. Md.   | Box 285   |   | ON A FARM?<br>YES NO   |
| 3. NAME OF   | First  | 2001100  | Middle   | Lost  | 4. DATE Month   | Day Yeor   |
| (Type ar print)  | Edwin  |  | (none)   | HANNA   | DEATH September   | 5 19 59  |
| S. SEX   | 6. COLOR OR RACE 7.  | MARRIED MA   | (  | B. DATE OF BIRTH  |   | ER 1 YEAR IF UNDER 24 HRS.   |
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| during most of work  | N (Give kind of work done ing life, even if retired)   | 10b. KIND OF   | BUSINESS OR IND  |   | .,  | TITIZEN OF WHAT COUNTRYS   |
| U.S. NAVY (I   | RETIRED)   |  |  | New York  | l   | J.S.A.   |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN N   | AME   |  |
| Arthur HAl   | NNA  |  |  | Margaret D  | ONOVAN  |  |
| 15. WAS DECEASED EVER  | IN U. S. ARMED FORCES?   |  | SECURITY NO.   | INFORMANT   | Address   |  |
| (Yes, no, or unknown)  | If yes, give war or dates of service)  | 230 4  | 2 1072 (W  | ife) Selma E.   | HANNA (Same as  | (2#2   |
|  | THE CO. I  |  |  | TTO LOCKET TO   | THE COURS OF  | INTERVAL BETWEEN   |
|  | TH [Enter only one cause ; TH WAS CAUSED BY:   |  |  |   |   | ONSET AND DEATH  |
| PARI I. DEAI   | IMMEDIATE CAUSE (a)  | Conges   | stive Fail   | Lure  |   | 3 day s  |
| 420.0  | DUE TO   |  |  |   |   |  |
| Canditions, if an  |  | Srteri   | oscleroti  | c Heart Diseas  | e   | 3 years  |
| gove rise to in<br>couse (a), stating t  |  |  |  |   |   |  |
| lying couse lost.  | (c)  |  |  |   |   |  |
| 1 ./ 0 00000 1031.   | (-)  | ONE CONTRIBI   | ITING TO DEATH BL  | T NOT RELATED TO THE TERM   | NAL DISEASE CONDITION GIVEN IN PA   | ADT 1/-) 10 MAC ALITOPSY   |
|  | ER SIGNIFICANT CONDITIO  | ONS CONTRIBE   | JINO 10 DEATH OF   |   |   | PERFORMED? YES NO  |
| PART II. OTH  PART II. OTH  OR CONTRIBUTING  (IF EITHER, NOTIFY)   |  |  | UNIT AT  | RED. (Enter noture of injury in F   |   | PERFORMED?   |
|  | S UNDERLYING D 20b. CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Day, Yeor 2   | DESCRIBE HO  | OW INJURY OCCURR   | ET 61.1   | ort I or Port II of item 18.)   | PERFORMED?   |
| PART II. OTH  PART II. OTH  20a. ACCIDENT WAR OR CONTRIBUTING (IF EITHER, NOTIFY II.  20c. TIME OF INJURY Hour a. m. p. m.   | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Day, Yeor 2 19  | DESCRIBE HO  20d. INJURY Of While No at work at the      | CCURRED 20e. F   | RED. (Enter noture of injury in P<br>PLACE OF INJURY (Home, form<br>foctory, street, office bldg., etc.   | ort I or Port II of item 18.)  20f. (City or town)  | PERFORMED? YES NO (Stote)  |
| PART II. OTH  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJURY Hour a. m. p. m.  21. I certify the  | S UNDERLYING   20b.   2 | DESCRIBE HO  20d. INJURY Of While Not at work at work to | CCURRED 20e. F   | PLACE OF INJURY (Home, farm, octory, street, office bldg., etc.   | 20f. (City or town) eptember, 1959, that I  | YES NO (County) (Stote   |
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| PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJURY Hour a. m. p. m.  21. I certify the alive an 5 Se  ACTUAL SIGNATURE PHYSICIAN'S NAME TYPE  | S UNDERLYING   20b.   2 | 20d. INJURY OF While No at work of the ceased from 19 59 | CCURRED 20e. For twhile and that death and that death and that death and the control of the cont | PLACE OF INJURY (Home, form foctory, street, office bldg., etc. ber 1959, ta5 Sth accurred at 8:20A  M.D. U.S. Naval H  U.S. Naval R  OR CREMATORY                  | 20f. (City or town)  eptember , 1959, that I  M, fram the causes and an tabbress (Street, city or town, stote)  ospital, Bethesda  22d. LOCATION (City, town, or caunty | (County) (State)   |
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|                                 |  | 104   | 39                          | CERT               | IFICA      | TE OF I                            | DEATH          |  | 17.52                         | Reg. Di                        | ist. No.   | 215  |
|---------------------------------|--|---|-----------------------------|--------------------|------------|------------------------------------|----------------|--|-------------------------------|--------------------------------|------------|--|
| o. COL                          | of DEATH<br>UNITY<br>Ontgome           | rv  |                             | MAR                | YLAND      | 2. USUAL RESI                      | and            | ere deceased live                          |                               | Itgome                         |            | e admission)                                 |
| b. CITY                         |  | outside corporate lim<br>rest town)                           | its, write                  | c. LENGTH OF STATE |            |                                    | TOWN (If or    | utside corporate                           | limits, write                 | e RURAL ond                    | give near  | rest town)                                   |
| d. NA                           | ME OF HOSPITAL<br>INSTITUTION<br>S. Na | l (If not in hospitol, s<br>val Hosp                          | give street o               | oddress)           |            | d. STREET A                        |                | Parkhi                                     | 111 I                         | Drive                          |            | ON A FARM? YES NO                            |
| 3. NAME<br>DECEA<br>(Type of    | or print)                              | Burt  |                             | Middl<br>11 S      | 311        | HANSC                              |                | 4. DATE<br>OF<br>DEATH                     |                               | Month<br>tember                |            | 19 59  |
| s. sex<br>Mal                   |  | 6. COLOR OR RACE  Taucasia                                    |                             | D DIVORC           |            | . DATE OF BIRT                     |                | 9. A                                       | GE (In year<br>ost birthdo)   | y) Months                      | Doys Doys  | Hours Min.                                   |
| Ma                              | ng most of working ariner              | I (Give kind of working life, even if retired                 | 1)                          | .S.Navy            | OR INDUST  | Mi                                 | chiga          | an   | у)                            |                                | J.S.       | WHAT COUNTRY?                                |
|                                 | er's NAME<br>arton S                   | . HANSON  | I                           |                    |            | Ruby                               |                | BARNES                                     |                               |                                |            |  |
| 15. WAS I<br>(Yes, no, or<br>Ye | Unknown) (It                           | IN U. S. ARMED FOR  | CES? 16. 9                  | 59                 | 201-10     | ospita                             | l Red          | cords                                      | Δ                             | Address                        |            |  |
| 1B. C                           |  | H [Enter only one co<br>H WAS CAUSED BY:<br>MMEDIATE CAUSE (c | -                           | teriona            | 1)]        | lung,                              | leilate        | raf E                                      |                               |                                |            | RVAL BETWEEN<br>ET AND DEATH                 |
| gov                             | 10.0                                   | DUE TO  | )                           | .ly                | Ten        | we e                               | me,            | Tastas                                     | Ro                            |                                | 3          | Ymo.   |
| CATION                          |  |   |                             | ONTRIBUTING TO D   | EATH BUT N | NOT RELATED TO                     | THETERMI       | NAL DISEASE CO                             | NOITION                       | GIVEN IN PAI                   | RT 1(o) 15 | 9. WAS AUTOPSY<br>PERFORMED?<br>YES NO       |
| ≥ OR C                          | ONTRIBUTING [                          | UNDERLYING  CAUSE OF DEATH CAUSE EXAMINER)                    | 20b. DESC                   | CRIBE HOW INJURY   | OCCURRED.  | . (Enter nature o                  | of injury in F | ort I or Port II o                         | of item 1B.)                  |                                |            |  |
|                                 | TIME OF INJURY                         | Month, Doy, Ye  | While                       | Not while          |            | CE OF INJURY<br>ory, street, offic |                |  | town)                         |                                | (County)   | (Stote                                       |
| 2                               | p. m.                                  | 19  | or work                     |                    |            |                                    |                | §  |                               |                                |            |  |
| 21. aliv                        | p. m.  I certify that te on Sep t      | t I attended the  |                             | ed from June       | at death o | accurred at                        | 9 P            | ept 2 M, from the ADDRESS (Street, aval Ho | causes<br>city or to          | and an th                      |            | stated above                                 |
| 21. aliv                        | I certify that the on Sept             | g. John   | le decease<br>, 19<br>MSON, | ed from June       | , USN      | accurred at                        | 9 P<br>S. N    | M, fram the                                | causes<br>city or to<br>ospi1 | and an th<br>wn, stote)<br>tal | e date     | the deceased stated above DATE SIGNED 1-3-59 |

PHYSICIAN: The law requires that the death certificate be executed within 24 haurs campletely filled in pup attending physician After this certificate has been signed by detached for use as the burial-transit page 3 should be may be retaing TO FUNERAL DI

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W.W.Chmabers Funeral Home, 3072 M St. NW

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10440

10402

CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH o. COUNTY 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND Montgomery Montgomery Marvland b. CITY OR TOWN (If outside carporote limits, write c. CITY OR TOWN (If oulside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 RURAL and give nearest town) Rural - Clagettsville Rural - Clagettsville d. NAME OF HOSPITAL (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO X RFD Mt. RFD NAME OF 4. DATE First Middle Last Month Day Year DECEASED DEATH (Type or print) 10 Margaret Harrell Sent 1959 Mae 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Months Days Hours Min. DIVORCED T WIDOWED | 74 yrs. Female White 10a. USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) None None Washington. IISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harrison S. Harrell Margaret Nebringer 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address No Mrs Rena Brown INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: DUE TOOL Conditions, if any, which gove rise to immediate **DUE TO** couse (o), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO T 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED (Stote) Doy, Year (County) foctory, street, office bldg., etc.) Hour o. m. While Not while of work of work 1959, that I lost sow the deceased 21. I certify, that I ottended the deceased from and that death occurred at 7:20am, from the causes and on the date stated above. alive on ADDRESS (Street, out or town, stote) ACTUAL SIGNATURE PHYSICIAN'S James P. Kerr NAME (Type) Damascus\_Md 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or caunty) (Stote) Boonesboro. Boonesboro Cemetery ADDRESS 24b. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR DATE SEP 2 2 '59 Damascus, Cirilian St. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Lincoln Cemetery

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anor, Md.

24b. REGISTRAR'S SIGNATURE

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23. FUNERAL DIRECTOR'S SIGNATURE

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| -0210  |                                      |                                |                        | Keg. Dist. 1                               | 10.                                     |
|--|--------------------------------------|--------------------------------|------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY  | MARYLAND                             | 2. USUAL RESIDENCE (W          |                        | institution: Residence b                   | pefore admission)                       |
| b. CITY OR TOWN (If outside corporate limits, write RIPAL one give negrest town)  Kensing to n   | c. LENGTH OF STAY IN 1b              | 7                              |                        | , write RURAL and give                     | A                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION   | oddress)                             | 3214 Se                        | land Stud              |  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF DECEASED (Type or print)  | Middle Hand                          | Lost                           | 4. DATE<br>OF<br>DEATH | Month<br>G                                 | Day Yeor 2 9 19 5 9                     |
| 5. SEX 6. COLOR OR RACE 7. MARRI  4. WIDOWE  | ED NEVER MARRIED DIVORCED DIVORCED   | Rebruary 1845                  |                        | In years IF UNDER 1 YE rithday) Months Doy | AR IF UNDER 24 HRS.<br>ys Hours Min.    |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. I during most of working life, even if retired)   | KIND OF BUSINESS OR INDU             | STRY 11. BIRTHPLACE (Stote     | or foreign country)    | 12. CITIZEN                                | OF WHAT COUNTRY?                        |
| 13. FATHER'S NAME  | Then                                 | 14. MOTHER'S MAIDEN            | NAME                   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)  |                                      | ecords at                      | Sanitariw              | Address<br>m-Kensing                       | ton,Md.                                 |
| 1B. CAUSE OF DEATH [Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO  Conditions, if any, which gove rise to immediate DUE TO | o for (o), (b), and (c).]            | sufficier<br>levoste           | ay a mu                | chsien                                     | hterval between onset and defin         |
| lying cause last. (c)  | ONTRIBUTING TO DEATH BUT             | NOT RELATED TO THE TERM        | MINAL DISEASE CONDIT   | TON GIVEN IN PART 1/a                      | al 10 WAS AUTOPSY                       |
| ZOG. ACCIDENT WAS UNDERLYING   20b. DESC   | RIBE HOW NJURY OCCURRE               | populit                        | eal ar                 | terry                                      | PERFORMED? YES NO NO                    |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  3 20c. TIME OF INJURY Month, Doy, Year 20d. IN  | JURY OCCURRED 20e. PL                | ACE OF INJURY (Home, for       | m, 20f. (City or town) | (Coun                                      | nty) (Stote)                            |
| Hour a.m. While  | Not while fac                        | tory, street, office bldg., et | (c.)                   |  |   |
| 21. I certify that I attended the decease alive an 2 Sept., 19   |                                      | accurred at 8 45               |                        |  |   |
| PHYSICIAN'S HELBELT M  | ARTYNIR                              | Buth                           | isdu M                 | nd.  | 319                                     |
| 220. DATE THEREOF 10/1/59  | 22c. NAME OF CEMETERY OF Fort Lincol | n Crematory                    | y Prince               | Georges C                                  | (Stote)                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co2901   | ADDRESS Wash.                        | DC 24g, REC                    | D BY REGISTRAR 24      | Orthun & Ha                                |   |

moy be retaine the haspital or attending physician. **D FUNERAL DIM. (OR:** After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the registrar priar to burial, cremation, or remavol, and in any event within 72 haurs offer-death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, moy be retaine

death. Page 4

VS A15 (4) 15M 9/5B

Andrew Committee The new spine of the Cart and the Cart PE MAN COLD IN STATE OF THE STA TO SEE THE PROPERTY OF THE PRO . Distriction of security Property and the state of the property of the security of the securi the S. H. Mirne Co. - reconstituted Sur. No. 1.

## CERTIFICATE OF DEAT

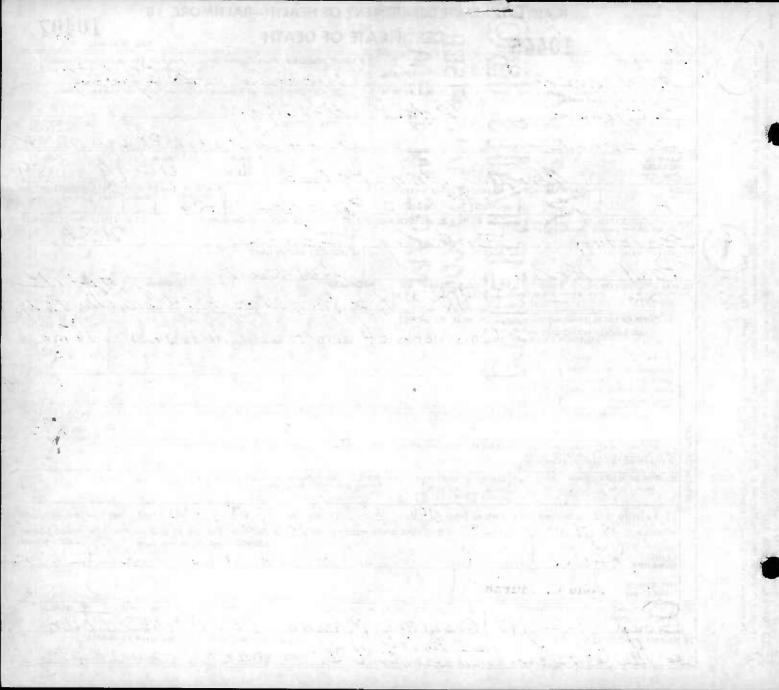
|  |   | 10444   | CERTIF                      | CAI       | OF DEAT  | П                       |   | Reg. Di   | st. No.     |   |
|--|---|---|-----------------------------|-----------|--|-------------------------|---|-----------|-------------|---|
| 1. PLACE OF<br>o. COUNT                  |   | TGOMERY   | MARYLA                      |           | USUAL RESIDENCE (WO. STATE MARYI                 |                         | d lived. If institution b. COUNTY             |           | TGOME       |   |
| b. CITY OF                               | R TOWN (If or ond give near SII                     | utside corporate limits, write<br>est town)<br>VER SPRING     | c. LENGTH OF STAY IN        | ( 1b      | c. CITY OR TOWN (IF                              | outside corpo<br>R SPRI |   | URAL ond  | give neares | t town)                                   |
|  |   | (If not in hospital, give street 124 Briggs-C                 |                             |           | d. STREET ADDRESS<br>2124 Brig                   | gs-Cha                  | ney Road                                      |           |             | S RESIDENCE<br>ON A FARM?<br>ES NO        |
| 3. NAME OF<br>DECEASED<br>(Type or p     | rint)   | Sarat   | Middle E 11                 | len       | Hayghe   | 4. DATE<br>OF<br>DEATH  | Mon<br>Se                                     | th<br>pt. | Day<br>23   | Yeor<br>19 59                             |
| 5. SEX<br>FEMA                           |   | T.PLITT PINE  | ARRIED NEVER MARRIED        | - 6       | ATE OF BIRTH<br>14/84                            |                         | 9. AGE (In years<br>lost birthdoy)<br>75 yrs. | Months    |             | UNDER 24 HRS.                             |
| 10o. USUAL C<br>during m<br>Homen        | iost of working                                     | (Give kind of work done 10 plife, even if retired)            | Own home                    | INDUSTRY  | 11. BIRTHPLACE (Stote<br>Washingt                |                         | _   |           | S.A.        | VHAT COUNTRY                              |
| 13. FATHER'S WILL                        |   | TRY ARNOLD  |                             |           | MOTHER'S MAIDEN                                  |                         | I MELSON                                      |           |             |   |
| 15. WAS DEC<br>(Yes, no or unkn<br>NO    |   | N U. S. ARMED FORCES? 1<br>res, give war or dates of service) | 6. SOCIAL SECURITY NO. NONE | 17. INFO  | MANT<br>Villiam H.                               | Hayghe                  | , 9909 W<br>Silver                            | oodbu     |             |   |
| Condit<br>gove (<br>couse (c<br>lying co | ions, if ony, rise to immo), stoting the ouse lost. | under-  | interior cl                 | proti     | e Heart  |                         | ad englin                                     |           | 5           | years.                                    |
| 20g. ACC                                 | IDENT WAS I   | INDERLYING IT 20b. D  | S CONTRIBUTING TO DEAT      |           |  |                         |   | EN IN PAR |             | PERFORMED?                                |
| 3 20c. TIME                              | OF INJURY or o.m. p. m.                             | Whi   |                             |           | OF INJURY (Home, for<br>street, office bldg., et |                         | or town)                                      | (1        | County)     | (Stote)                                   |
| 21. I co                                 | on  | I attended the dece<br>9/11/, 19                              |                             | leath occ | , 1958, to<br>curred at 4:45<br>880 / Cs         |                         |   | nd an t   |             | the decease<br>stated above<br>DATE SIGNE |
| PHYSICIA<br>NAME (T                      | уре)  | ussell B  | 7,7,7,1                     | & M       | D, Silver  | rspri                   | ng h  | d.        |             |   |
| BUNCYA                                   | CREMATION,  | 22b. DATE THEREOF<br>9/25/59                                  | CONGRESSIO                  |           |  |                         | NG TON, D                                     |           |             | (Stote)                                   |
| WARNI                                    | DIRECTOR'S SER E P                                  | UMPHREY INC   | . ADDRESS<br>SILVER SE      | PRING,    |  | D BY REGIST             | 0   | TRAR'S SI |             |   |

funeral director, snould be filed with ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page of mplenty filled in pers. Pages 1 and TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exemaly be retained by the hospital or attending physician.

TO FUNERAL DESTRUCTION OF STATES After this certificate has been signed by the attending physician and a page 3 should be detached for use as the burial-transit permit. Then please remave carbon the registrar prior to burial, cremation, ar remaval, and in any event within 72 hours after de-VS A15 (4) 15M 9/55

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FUNERAL 10 VS A15 (4) 15M 9/5B

23. FUNERAL DIRECTOR'S SIGNATURE

Rock Creek Cemetery Washington. D.C. 24b. REGISTRAR'S SIGNATURE 24g, REC'D BY REGISTRAR

Cithun & Krous

0408

e. IS RESIDENCE

U.S.A.

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPS PERFORMED?

(Stote)

YES NO

(Stote)

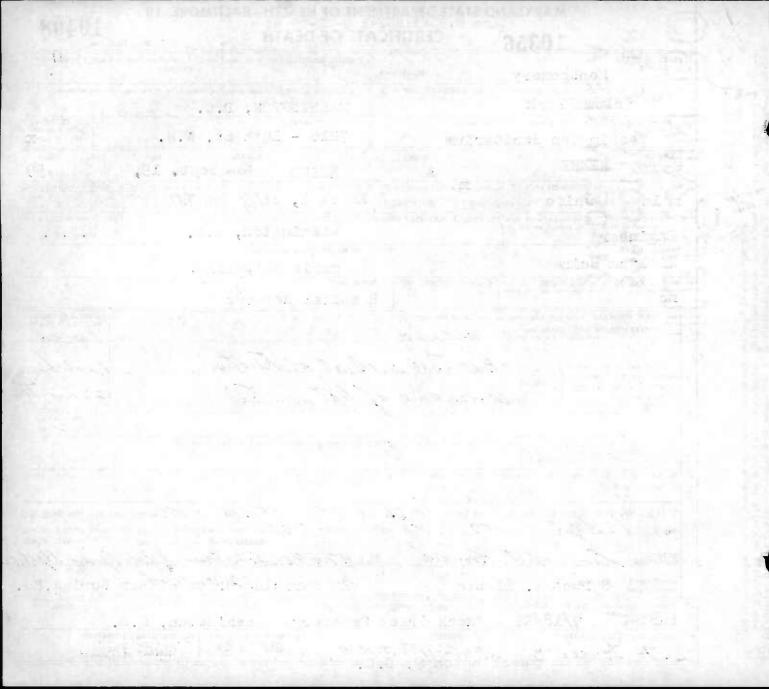
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(County)

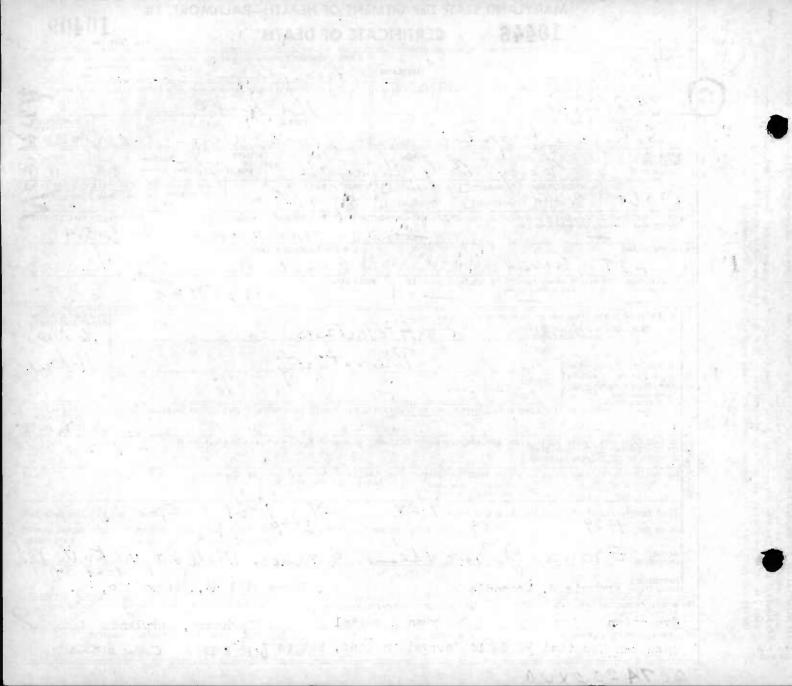
ON A FARM?

YES NO TO

Yenr



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



# TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4, may be retained by the haspital or attending physician. TO FUNERAL D OR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 shauld be filed with the registrar prior to burial, cremation, ar removal, and in any event within 72 haurs after death

VS A1S (4) 15M 9/55

195

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10117

CEPTIFICATE OF DEATH

10410

| 10441  | CERTIFIC                   | AIL OI DEA   | •                         | Reg. Dist. N                            | o.                                      |
|--|----------------------------|--|---------------------------|---|---|
| 1. PLACE OF DEATH O. COUNTY  ON THE PROPERTY OF THE PROPERTY O | MARYLAND                   | 2. USUAL RESIDENCE (                                     |                           | If institution: Residence be<br>COUNTY  | fore admission)                         |
| b. CITY OR TOWN III outside corporate limits, write RURAL and give nearest town)   | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (  | f outside corporate lim   | nits, write RURAL and give n            | earest town)                            |
| d. NAME OF HOSPITAL (II not in hospital, give street of institution  | oddren)                    | d. STREET ADDRESS  | ne                        |   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF DECEASED (Type or print) Edwin  | . Stanto                   | 1 Henry  | 4. DATE<br>OF<br>DEATH    | Solot                                   | Poy Year<br>1959                        |
| 5. SEX    6. COLOR OR RACE   7. MARR WIDOWE  | IED NEVER MARRIED          | 8. DATE OF BIRTH 24 Mary                                 | 1891 1891 G               | birtidoy) yrs.   Months   Doys          | AR IF UNDER 24 HRS. Hours Min.          |
| 100. USUAL OCCUPATION (Give kind of work done) 10b. during most of working life, even if retired)  | KIND OF BUSINESS OR IND    | Wood   | u. DC                     | 12. CITIZEN                             | OF WHAT COUNTR                          |
| Edwin Starton  | Henry :                    | 14. MOTHER'S MAIDEN                                      | NAME BERS                 | se                                      |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?  (Yes, no, or unknown)  (If yes, give wer or delete of service)   | 32-01-6278-                | Wite - T   | sake B                    | Herry                                   | Same                                    |
| 1B. CAUSE OF DEATH [Enter only one cause per lin PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  | ne for (o). (b). ond (c).] | of Prosta  | to with                   |   | TERVAL BETWEEN NSET AND DEATH           |
| Conditions, if ony, which (b)  |                            |  |                           |   | 0                                       |
| gove rise to immediate couse (a), stating the under-lying couse lost.  |                            |  |                           |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION OR CONTRIBUTING OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | CONTRIBUTING TO DEATH BY   | THOT RELATED TO THE TER                                  | MINAL DISEASE CONE        | DITION GIVEN IN PART 1(0)               | 19. WAS AUTOPSY PERFORMED? YES NO       |
|  | CRIBE HOW INJURY OCCUR     | RED. (Enter noture of injury                             | n Port I or Port II of it | tem 1B.)                                |   |
| 20c. TIME OF INJURY Month, Day, Year 20d. In Hour a.m. 19 while ot worl  | Not while                  | PLACE OF INJURY (Home, for octory, street, office bldg., | orm, 20f. (City or tow    | n) (Count                               | y) (State)                              |
| 21. I certify that I attended the decease alive an   |                            | , 1955, to   | Sapt                      | , 1954, that I last causes and an the d |   |
| ACTUAL SIGNATURE TANK  | slina                      | MD 1837E   | ADDRESS (Street, cit      |   | DC i Sel                                |
| PHYSICIAN'S HORAL A. H   | orstman                    | Jn 183   | EYE ST                    | N.W. WA                                 | SH.,D.C.                                |
| 220. BURIAL, CREMATION, 225. DATE THEREOF 9/3/59   | ROCK CREE                  | 11/  | WASH IN                   | ity, town, or county)                   | (Stote)                                 |
| 3. FUNERAL DIRECTOR'S SIGNATURE 175  | 6 Pa. Ave.                 | NDCW . 24a. RE   |                           | 24b. REGISTRAR'S SIGNAT                 |   |

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|               | Water Street Street Company of the   |                   | 03/8/0   |  |
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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10448

**CERTIFICATE OF DEATH** 

Dam Dies M.

10411

|   |   |                                   |  |   |                                |                              |  | Keg. Dist.    | 140.        |                          |
|---|---|-----------------------------------|--|---|--------------------------------|------------------------------|--|---------------|-------------|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                    | MONTGOMERY  |                                   | MARYLAND                                   | II o STATE                                | MARYL                          | ere deceased live<br>AND     |  | MONTGO        |             | sion)                    |
| b. CITY OR TOW<br>RURAL and giv                                   | N (If outside corporate limite negrest Jown) SILVER SPRI            | ts, write c. l                    | ENGTH OF STAY IN 16                        | c. CITY OR                                |                                | R SPRIN                      |  | URAL and give | nearest tow | n)                       |
| d. NAME OF HO<br>OR INSTITUTION                                   | SPITAL (If not in hospital, g<br>DN10,005 GREE                      | ive street oddre<br>LEY AVE       | ess)<br>•                                  | d. STREET                                 |                                | EELEY A                      | VENUE                                  |               | ON          | SIDENCE<br>A FARM?<br>NO |
| 3. NAME OF<br>DECEASED<br>(Type or print)                         | Fir<br>SUSAN  |                                   | Middle<br>CLAIBORNE                        | HOLLA                                     |                                | 4. DATE<br>OF<br>DEATH       | Mon<br>SEPI                            |               | Day<br>26   | Year<br>1959             |
| 5. SEX<br>FEMALE  | 6. COLOR OR RACE WHITE  | 7. MARRIED [ WIDOWED              | NEVER MARRIED DIVORCED                     | B. DATE OF BIRT<br>11/22/80               |                                | 9. A                         | GE (In years<br>ost birthdoy)<br>Byrs. | Months Do     |             | -                        |
| Clerk(re  | ATION (Give kind of work working life, even if retired tired) Burea | done 10b. KING<br>)<br>u of En    | of Business or Inc<br>US Gov to<br>graving | VIR                                       | GINIA                          |                              | y)                                     |               | N OF WHA    | T COUNTRY                |
| JOHN L.   | SMITHER   |                                   |  | 14. MOTHER'S                              |                                | J. GARY                      |  |               |             |                          |
| 15. WAS DECEASED (Yes, no, or unknown) NO                         | EVER IN U. S. ARMED FOR<br>(If yes, give war or dates of s          | ervice)                           | NE   | informant<br>irs. Leon                    | ora Ho                         | -                            | 12 Emer                                | son St        | •           |                          |
| Conditions, is gove rise to couse (a), stot lying cause le        | f any, which by immediate and the under-                            | , Eeu                             | rion as                                    | d Certe                                   | nom                            | vosi                         | s<br>osi                               |               | Sy          | int.                     |
| ICATIO  | OTHER SIGNIFICANT CON   |                                   |  |   |                                |                              |  | EN IN PART I  | PERFO       | AUTOPSY<br>DRMED?        |
|   | WAS UNDERLYING  <br>NG   CAUSE OF DEATH<br>IFY MEDICAL EXAMINER)    | 20b. DESCRIBE                     | HOW INJURY OCCUR                           | RED. (Enter nature o                      | of injury in P                 | art I or Part II o           | f item 18.)                            |               |             |                          |
| 20c. TIME OF IN<br>Hour a.<br>P.                                  | 10  | or 20d. INJUR<br>While<br>of work | Not while                                  | FLACE OF INJURY<br>factory, street, affic | (Home, farm,<br>e bldg., etc.) | 20f. (City or t              | own)                                   | (Cou          | inty)       | (Stole)                  |
| 21. I certify alive an  ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) | ARTHU   | deceased f                        | e l'                                       | , 19_ <u>7</u> th accurred at             |                                | M, fram the ADDRESS (Street) | e causes a                             | stote         | date stat   |                          |
|   | TION, 22b. DATE THEREC  |                                   | E. NAME OF CEMETERY  T. LINCOLN            |   |                                | 22d. LOCATION<br>PRINCE      |  | or county)    | (Sta        | te)                      |
| 23. FUNERAL DIRECT  | OR'S SIGNATURE  |                                   | ADDRESS<br>SILVER SPRI                     | ING, MD.                                  |                                | BY REGISTRAR<br>P 2 9 '59    | 24b. REGIS                             | TRAR'S SIGN   | ATURE       |                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4 VS A15 (4) 15M 9/55

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTUROFE,

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10412

10449 CERTIFICATE OF DEATH

Reg. Dist. No. 215

|   | 1. PLACE OF DEATH o. COUNTY Montgome            | rv   |                        | MAR                   | YLAND            | d. STATE  Maryland                                 |                        | d lived. If instituti<br>b. COUNTY |                  | de befor  | e admiss  | ion)           |
|---|---|--|------------------------|-----------------------|------------------|--|------------------------|------------------------------------|------------------|-----------|-----------|----------------|
|   | b. CITY OR TOWN (IF RURAL ond give nec Bethesda | autside carporate limi<br>prest town)          | ts, write              | 105 day               |                  | c. city or town (if                                | f outside corpo        | orate limits, write R              | URAL and         | give nea  | rest tawn | )              |
|   | d. NAME OF HOSPITA                              |  | ive street of<br>thesd | ddress)               |                  | d. STREET ADDRESS                                  | ioma R                 | oad                                |                  |           |           | DENCE<br>FARM? |
|   | 3. NAME OF<br>DECEASED<br>(Type or print)       | Fir  |                        | Middle                |                  | Last   | 4. DATE<br>OF<br>DEATH | Mor                                |                  | Do:       |           | Yeor<br>19 59  |
|   | S. SEX  | Walter   |                        | Cole:                 | - 0.0            | OLT<br>DATE OF BIRTH                               | DEATH                  | Septem 9. AGE (In years            | IF UNDER         |           |           |                |
|   | Male  | White  | WIDOWED                |                       |                  | 10-14-99   |                        | last birthdoy)<br>59 yrs.          | Months           | Doys      | Hours     | Min.           |
|   | 10o. USUAL OCCUPATIO                            | N (Give kind af wark ing life, even if retired | dane 10b. K            | IND OF BUSINESS       | OR INDUSTR       | Y 11. BIRTHPLACE (Stat                             | te or foreign c        | auntry)                            | 12. CITI         | ZEN OF    | WHATC     | OUNTRY?        |
|   | U.S. Na   | Vy   | Go                     | vernmen               | t                | New Yor  | k                      |                                    | 1                | J.S       |           |                |
| Л | 13. FATHER'S NAME                               |  |                        |                       |                  | 14. MOTHER'S MAIDEN                                | NAME                   |                                    |                  |           |           |                |
|   | Walter H.                                       | НОТЛ   |                        |                       | - 51             | Virgini  | a ERA                  | RY                                 |                  |           |           |                |
|   | 1S. WAS DECEASED EVER                           | IN U. S. ARMED FOR                             | CES? 16. SC            | OCIAL SECURITY NO     | D. INF           | DRMANT   |                        | Add                                | ress             |           |           |                |
|   | Yes W   | f yes, give war or dates of s                  |                        |                       | (wi              | fe) Julia  | D. H                   | OLT Sam                            | e as             | #2        |           |                |
| ı |   | TH [Enter only one co                          | use per line           | for (o), (b), and (c) | 1 0              |  |                        |                                    |                  |           | RVAL BE   |                |
|   | PART I. DEAT                                    | H WAS CAUSED BY:<br>IMMEDIATE CAUSE (o         | , de                   | mysh                  | 0 20             | reome  |                        |                                    |                  | 7         | 69        | 72             |
|   | 200.1   | DUE TO   | 0                      |                       |                  |  |                        |                                    |                  | 1 3       | ,         |                |
|   | Conditions, if an                               |  | )                      |                       |                  |  |                        |                                    |                  |           |           | 1              |
|   | gave rise to in<br>cause (o), stating t         | mediate (                                      |                        |                       |                  |  |                        |                                    |                  |           |           |                |
|   | lying cause lost.                               | (c   | )                      |                       |                  |  |                        |                                    |                  |           |           |                |
|   | PART II. OTH                                    | ER SIGNIFICANT CON                             | DITIONS CO             | NTRIBUTING TO DE      | ATH BUT NO       | OT RELATED TO THE TER                              | MINAL DISEAS           | E CONDITION GIV                    | EN IN PAR        | T 1(a) 19 | PERFO     | RMED?          |
| 4 |   | LINDERIVING C                                  | 20h DECCE              | NIBE HOW INTINES      | OCCUPPED         | Enter nature af injury in                          | - Pt I P               | t II of itom 18 1                  |                  |           | YES IN    | № □            |
|   | OR CONTRIBUTING                                 | CAUSE OF DEATH                                 | ZOB. DESCR             | TIBE HOW INJURY       | OCCURRED.        | Enter nature at injury ii                          | n ran i ar rai         | i ii oi iieni ib.)                 |                  |           |           |                |
|   | 20c. TIME OF INJURY<br>Haur a. m.<br>p. m.      | Month, Doy, Yes                                | While<br>at wark       | Not while             | 20e. PLAC foctor | OF INJURY (Hame, for<br>y, street, office bldg., e | rm, 20f. (City         | or tawn)                           | (0               | County)   |           | (Stote)        |
|   |   | at I attended the                              |                        |                       | Tune             | , 19 59 to 2                                       | 8 Sen                  | t. 1050                            | ) 46 A         - |           |           |                |
|   |   |  |                        |                       |                  | ccurred at 0:15                                    |                        |                                    |                  |           |           |                |
|   | alive dil 20                                    | Depoembe.                                      | <u>-, 17</u>           | Z, and tha            | r dearn o        | ccorreg of   |                        | treet, city or town,               |                  | aare      |           | E SIGNED       |
|   | ACTUAL B  | M. WEBB  | LT M                   | C USN                 | M.:              | U.S. Nav   |                        |                                    |                  | esd       | a Mo      | i.             |
| 1 | PHYSICIAN'S<br>NAME (Type)                      | Tale:  | Si. a                  | hold                  |                  | U.S. Nav   | al Ho                  | spital,                            | Beth             | esd       | -         | 28-59          |
|   | 220. BURIAL, CREMATION                          | - 1  |                        | 22c. NAME OF CEM      |                  |  |                        | TION (City, tawn,                  | or county)       |           | (Stat     | e)             |
|   | Burla!  | 10/-1-59                                       | 1 1                    | Arlingt.              | on Na            |  |                        | ington                             | Vir              |           |           |                |
|   | 23. INNERAL DIRECTOR'S                          |  | Then                   |                       | ne '             |  | C'D BY REGIS           |                                    | STRAR'S SIG      |           |           |                |
|   | R.A. Pump                                       | hrev 755                                       | 7 Wis                  | consin                | Ave.             | Bethe sda  | MOLET                  | 1 '59                              | arthur           | 1 7       | Trame     |                |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10450 CERTIFICATE OF DEATH

10413

|   | Reg. Dist. No.   |
|---|--|
| 1. PLACE OF DEATH a. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |
| MONTGOMERY MARYLAND   | MARYLAND 6. COUNTY MONTGOMERY  |
| b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)   |
| SILVER SPRINGS  | 565, LUER SPRINGS  |
| d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION 8674 PINEY BRANCH ROAD   | 1 d. STREET ADDRESS  8674 PINEY BRANCH POAD YES NOT  |
| NAME OF First Middle  | Last 4. DATE Month Day Year  |
| (Type or print) BARBARA   | FORSEY DEATH PURPT 4 1959  |
| SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 H/S.   |
| FEMALE WHITE WIDOWED DIVORCED   | JAN. 4 1889 70 yrs.  |
| 0a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)  |  |
| HOUSE USIFE 3. FATHER'S NAME  | MARYLAND 4.5A  |
| , rainers name  | 14. MOTHER'S MAIDEN NAME   |
| 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.   | KHUDA MAKINE   |
| 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. [If yes, give wor or dotes of service]  | INFORMANT Address  |
| // <i>/</i> :   | UFUS N HORSEY 8674 PINEY BR. RD  |
| 18. CAUSE OF DEATH [Enter only one cause perfline for (a), (b), and (c).]   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) / Cutte Pryou  | adul orfaction 3 says  |
| 420. DUE TO 0   |  |
| Conditions, if any, which ) (h) Kronery (   | Educin 3 Days  |
| gave rise to immediate  |  |
| lying cause last.   | lolus.   |
|   | T NOT BELATED TO THE TERMINAL DISEASE COMPLYION OF THE PLANT IN THE WAS ALTONOMY   |
|   | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \( \sum \) NO \( \sum \)   |
|   | ED. (Enter nature of injury in Part I or Part II of Item 18.)  |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. Pl Haur a. m. 19 While Nat while of wark at wark   | LACE OF INJURY (Hame, farm,   20f. (City ar tawn) (County) (State)   |
| Haur a. m.    Haur a. m.   While Nat while   fc   | actory, street, affice bldg., etc.)  |
| 77.   | 9 .50 . Sep. H . 39.   |
| 21. I certify that I attended the deceased from 1   | 1997, to 1997, that I last saw the decease   |
| alive on 19 7, and that death   | The state of the s |
| ACTUAL OF THE PROPERTY OF THE | ADDRESS (Street, city or town, state)  DATE SIGNE  |
| ACTUAL SIGNATURE / Ocurrey  | M.D. 0601-42911W   |
| PHYSICIAN'S NAME (Type) F.X. COUTENES   | , Stastungton De   |
| 20. BURIAL, EREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY C  | OR CREMATORY 22d. LOCATION (City, tawn, or caunty) (State)   |
| 9/5/59 FT. LINCO  | LN CEM. BLADENSBURG. MD.   |
| 3. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Washing   |  |
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| MARYLAND STATE DEPARTMENT OF | HEALTH-BALTIMORE, 18 |
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10414

10451 CERTIFICATE OF DEATH

| Rea   | Dist. | No |
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| west. |       |    |

| 10301  | keg. Dist. No.  |
|--|---|
| 1, PLACE OF DEATH o. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY. |
| Montgomery MARYLAND  | o. STATE Maryland b. COUNTY Montgomery  |
| b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn)                       | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)                          |
| Silver Springs   | 54 Silver Springs   |
| d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION                           | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
| 1706 Dublin Drive  | 1706 Dublin Drive   |
| 3. NAME OF DECEASED (Type or print) Gentley AP F Howell  | Lost 4. DATE Manth Day Year OF DEATH 9 1250   |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.  |
| Female White WIDOWED DIVORCED  | April 2, 1876 lost birthday) Months Doys Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR IND                             |   |
| during most of working life, even if retired)  housewife  Home   | Washington D. C. U.S.A.   |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
| ?  | ?   |
|  | INFORMANT Address   |
| (Yes, no. or unknown) (If yes, give war or dates of service)   | Carlton Howell 1706 Dublin Drive  |
| 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: | INTERVAL BETWEEN  |
| IMMEDIATE CAUSE (a)  | 2 Week  |
| 1100   | 20 mp   |
| Canditians, if any, which gove rise to immediate (b)   | To say of   |
| cause (a), stating the <u>under-</u> lying cause last.  (c) Described to                               | er foot smooth  |
| PART N. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU  | JT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?            |
| CAT  | YES NO  |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                    | IED. (Enter nature of injury in Port I or Part 11 of item 18.)  |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While Not while of work at wark              | PLACE OF INJURY (Home, form, 20f. (City or tawn) (County) (State) octory, street, office bldg., etc.)     |
| 21. I certify that I attended the deceased fram.   |   |
| alive on Seller, 15, 1959, and that deal   | 1-10/1/2  |
| 20 1000 10   | ADDRESS (Street, city or town, state) DATE SIGNE  |
| SIGNATURE Claud J. Malley  | MD/831 Varnum St N.F.   |
| PHYSICIAN'S/Eland SMadde   | = N Washington D.C.   |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY  |   |
|  | Cemetery Washington D. C.   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| Veal Funeral Home_ 4812 Ga. Ar   | re. N. WeatGEP 18 '59   arthur & Kraus  |
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10415

Reg. Dist. No.

| °            | COUNTY   | Montgome  | ry  | MARYLANI   | 11                                       | o. STATE Mary.   |                      | d lived. If institution b. COUNTY   | on: Reside                  | 20             | tgom          |                                   |
|--------------|--|---|---|--|--|--|----------------------|---|-----------------------------|----------------|---------------|-----------------------------------|
| b            | . CITY OR TOWN (II   | outside corporate limi<br>arest town)             | ts, write   | c. LENGTH OF STAY IN TI  | Ь  | c. CITY OR TOWN (IF  | outside corpo        | rote limits, write R  | URAL ond                    | give nea       | rest town     | )                                 |
|              | German   | town  |   | 6 years  | 1  | Ganin  | app/topm             | Ann Am  | hor_J                       | רוגע           | ~             |                                   |
| d            | OR INSTITUTION   | AL (If not in hospital, g                         | ive street o  | oddress)   |  | d. STREET ADDRESS  | 11111                |   | 001                         |                | e. IS RESI    | DENCE                             |
|              | The M  | arylander   | Home  | of Rest  |  | Ann  | Arbor                | Mich.   |                             |                |               | FARM?                             |
| 3. N         | NAME OF<br>DECEASED  | Fir   | st  | Middle   |  | Lost   | 4. DATE              | Mon   | th                          | Da             | , )           | rear .                            |
| (i           | Type or print)   | Ka  | te  | C.   |  | Hubbard  | OF<br>DEATH          | 9   |                             | 18             |               | 959                               |
| 5. SE        | EX   | 6. COLOR OR RACE                                  | 7. MARR   | IED NEVER MARRIED  | ] B. D                                   | ATE OF BIRTH   | Course !             | 9. AGE (In years  |                             |                | IF UNDE       | R 24 HRS.                         |
|              | Female   | White   | WIDOWE  | treat treat  |  | 6/13/71  |                      | lost biethdoy)<br>yrs.  | Months                      | Days           | Hours         | Min.                              |
| 10a.         | USUAL OCCUPATIO  | N (Give kind of work                              | done 10b.   | KIND OF BUSINESS OR IN   | DUSTRY                                   | 11. BIRTHPLACE (Stote  | or foreign o         | ountry)   | 12. CI                      |                |               | COUNTRY                           |
|              | Teacher  | retired   |   |  |  | Ohio   |                      |   |                             | U.S            | .A.           |                                   |
| 13. F        | ATHER'S NAME   |   |   |  | 1  | 4. MOTHER'S MAIDEN   | NAME                 |   |                             |                | •             |                                   |
|              | Alancer  | Slater  |   |  |  | Anne C   | hapman               |   |                             |                |               |                                   |
|              |  | IN U. S. ARMED FOR                                |   | SOCIAL SECURITY NO. 17   | , INFO                                   | RMANT  |                      | Addr  | ess                         |                |               |                                   |
| 1146         | no   | If yes, give wor or dates of s                    | HVICE)  |  | Rec                                      | ords-The Ma  | ryland               | er Hone   | of Re                       | st             |               |                                   |
|              | 18. CAUSE OF DEA   | TH [Enter only one co                             | use ger lin   | ne for (a), (b), and (c).]   |  |  | A                    | 1 5   |                             | INTE           | RVAL BE       | WEEN                              |
|              |  | TH WAS CAUSED BY:                                 | 11+   | in Belief  | RO                                       | un limme   | mula                 | delen   | 22                          |                | ET AND        |                                   |
|              | 422.1  | DUE TO  |   | - O************************************  |  | A J  | 30000                | 1 A A   |                             | -              | - A           | 1002                              |
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|              | Conditions, if ar  | mediate   | pu  | 1 Joins  | Jora                                     | mysor  | ny                   | feer 1  | ay .                        | - 1 '          | 2 GX          | 1002                              |
|              | couse (o), stoting t   | he under- DUE TO                                  |   |  | 0  |  | U                    | 0   |                             |                | 0             |                                   |
| z            | lying couse lost.  | ) (c  | DITION S  | Chitainian to occurr   |  |  |                      |   |                             |                |               |                                   |
| 일            | FAXI II. OIII  | EK SIGNIFICANT CON                                | DITIONS C   | CONTRIBUTING TO DEATH B  | ON IU                                    | I KELATED TO THE TERM  | INAL DISEAS          | E CONDITION GIV   | EN IN PAR                   | RT 1(0) 1      | PERFO         | RMED?                             |
|              |  |   |   |  |  |  |                      |   |                             |                |               |                                   |
| FICA         | 20- 455105151414   | - Independent of                                  | 001 DECE  |  |  |  |                      |   |                             |                | YES 🗌         | № □                               |
| H.           | 200. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY  | S UNDERLYING []  CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC   | CRIBE HOW INJURY OCCUR   | RRED. (E                                 | nter noture of injury in   | Port I or Port       | II of item 18.)   |                             |                | YES [         | но 🗌                              |
|              | OR CONTRIBUTING<br>(IF EITHER, NOTIFY)<br>20c. TIME OF INJURY  | CAUSE OF DEATH                                    | or 20d. IN  | NJURY OCCURRED 20e.  | PLACE                                    | OF INJURY (Home, form  | . 20f. (City         | P-4.3   | (                           | County)        | YES [         | NO [                              |
| -   L        | OR CONTRIBUTING<br>(IF EITHER, NOTIFY  | CAUSE OF DEATH                                    |   | NJURY OCCURRED 20e.  | PLACE                                    |  | . 20f. (City         | P-4.3   | (                           | County)        | YES [         |                                   |
| MEDICAL      | OR CONTRIBUTING<br>(IF EITHER, NOTIFY)<br>20c. TIME OF INJURY<br>Hour a. jr.<br>p. m.  | CAUSE OF DEATH MEDICAL EXAMINER)  Month, Day, Yea | 20d. IN<br>While<br>of work                             | NJURY OCCURRED 20e. Not while of work  | PLACE                                    | OF INJURY (Home, form, street, office bldg., etc   | . 20f. (City         | or town)  |                             |                |               | (Stote)                           |
| MEDICAL      | OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJURY HOUR G. p. p. m.  21. I certify the   | CAUSE OF DEATH MEDICAL EXAMINER)  Month, Day, Yea | 20d. IN<br>While<br>of work                             | Not while 20e.   | PLACE foctory                            | OF INJURY (Home, form, street, office bldg., etc., 1956 to 2   | 20f. (City           | or town)  | Z,that I                    | last sa        | w the         | (State)                           |
| MEDICAL      | OR CONTRIBUTING<br>(IF EITHER, NOTIFY)<br>20c. TIME OF INJURY<br>Hour a. jr.<br>p. m.  | CAUSE OF DEATH MEDICAL EXAMINER)  Month, Day, Yea | 20d. IN<br>While<br>of work                             | Not while 20e.   | PLACE foctory                            | OF INJURY (Home, form, street, office bldg., etc., 1956 to curred at   | 20f. (City           | or town)  9 , 19 5 9  | Athat I                     | last sa        | w the e       | (Stote)  decease d above          |
| MEDICAL      | OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJURY Hour a. p. p. m.  21. I certify the   | CAUSE OF DEATH MEDICAL EXAMINER)  Month, Day, Yea | 20d. IN<br>While<br>of work                             | Not while 20e.   | PLACE foctory                            | OF INJURY (Home, form, street, office bldg., etc., 1956 to curred at   | 20f. (City           | or town)  | Athat I                     | last sa        | w the e       | (Stote)                           |
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| MEDICAL      | OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJURY Hour a. p. p. m.  21. I certify the   | CAUSE OF DEATH MEDICAL EXAMINER)  Month, Day, Yea | decease   | Not while of work and that dec   | PLACE foctory                            | OF INJURY (Home, form, street, office bldg., etc., 1956 to Recurred at   | M, from              | or town)  9 , 19 5 9  | Athat I                     | last sa        | w the e       | (Stote)  decease d above          |
| WEDICAL 220. | OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJURY Hour a. p. p. m. 21. I certify the alive on ACTUAL SIGNATURE PHYSICIAN'S   | James P.  | decease  12 20d. IN While of work  decease  12 2  Kerr, | Not while of work and that dec   | PLACE foctory  1.5  ath oc               | OF INJURY (Home, form, street, office bldg., etc., 1936 to Recurred at Damas of Damas of the street, and the s | M, from ADDRESS (St. | or town)  9, 19.55  In the causes a reet, city or town, some town, sown, sown, sown, sown, sown, sown, sown | ,that I<br>nd on t          | last sa        | w the e       | (Stote)  decease d above TE SIGNE |
| WEDICAL      | OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJURY Hour a. p. p. m. 21. I certify the alive on  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)  BURIAL, CREMATION REMOVAL (Specify) | James P. J  | decease  12 20d. IN While of work  decease  12 2  Kerr, | M.D.  20e.  Not while of work of the decomplete of work of the decomplete of work of the decomplete of | PLACE foctory  1.5.  ath oc  M.D.        | OF INJURY (Home, form, street, office bldg., etc., 1936 to Recurred at Damas of Damas of the street, and the s | M, from              | or town)  9, 19.5. In the causes a reet, city or town, ary land   | ,that I<br>nd on t          | last sa        | w the e state | (Stote)  decease d above TE SIGNE |
| WEDICAL      | OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJURY Hour a. p. p. m. 21. I certify the alive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)  BURIAL, CREMATION REMOVAL (Specify)  | James P. J  | decease  12 20d. IN While of work  decease  12 2  Kerr, | Not while of work and that dea   | PLACE foctory  1.5.  ath oc  M.D.  OR CR | OF INJURY (Home, form, street, office bidg., etc., 1956 to be curred at  | M, from              | or town)  9 , 1953 In the causes a reet, city or town, aryland  TION (City, town, o   | 2, that I and on the state) | last so he dat | w the e state | (Stote)  decease d above TE SIGNE |

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**CERTIFICATE OF DEATH** 10454

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| Reg. | Dist. | No. |   |

| _        |   |   | -                             |                            |          |   |           |                        |                               |           |             |                     |               |
|----------|---|---|-------------------------------|----------------------------|----------|---|-----------|------------------------|-------------------------------|-----------|-------------|---------------------|---------------|
|          | PLACE OF DEATH  | 12,000 11   |                               | MARYL                      |          | o. STATE                                | NCE (WI   |                        | lived. If institu<br>b. COUNT | v         | idence befo |                     |               |
|          |   | f outside corporate lin                                   | nits, write                   | c. LENGTH OF STAY IN       | ч 16     |   |           |                        | ote limits, write             |           |             |                     |               |
|          | Bett  | nesda   |                               |                            |          | × Be                                    | thes      | da                     | 37                            |           |             |                     |               |
|          | OR INSTITUTION  | AL (If not in hospitol,                                   | give street                   | oddress)                   |          | 5718 M                                  |           | nlev S                 | treet                         |           |             |                     | FARM2         |
|          | 5718 Mc   | Kin Ley St.   | D-E                           | nesca, ria.                | - 1      |   |           | 1                      |                               |           |             |                     |               |
|          | NAME OF<br>DECEASED<br>(Type or print)                    | Laurence  | irst<br>2                     | Middle<br>D                |          | Jennin                                  | 95        | 4. DATE<br>OF<br>DEATH | Septer                        | nbe:      | r 12        |                     | Year<br>19 59 |
| 5.       | SEX   | 6. COLOR OR RACE  | 7. MARI                       | RIED NEVER MARRIED         | B.       | DATE OF BIRTH                           |           |                        | 9. AGE (In year               | -         | DER 1 YEAR  | -                   | _             |
|          | VIale   | White   | WIDOW                         |                            |          | ine 13, 1                               |           |                        | 56 yr                         | . 2       | 29          | Hours               | Min.          |
| 100      | during most of work                                       | ON (Give kind of work king life, even if retire at Econom | d)                            | KIND OF BUSINESS OR        | INDUSTR  | RY 11. BIRTHPLAC                        | Iow       |                        | untry)                        | 12.       | USA         | - WHAT C            | OUNTRY?       |
| 13.      | FATHER'S NAME   |   |                               |                            |          | 14. MOTHER'S M                          | AAIDEN    |                        |                               |           |             | 400                 | 1150          |
|          | Jack C. J   | ennings   |                               |                            | 94       | Anna G                                  | . C.      | Jenni                  | ngs                           |           |             |                     |               |
|          |   |   |                               | SOCIAL SECURITY NO.        | INF      | ORMANT                                  |           |                        | Ad                            | dress     |             |                     |               |
| ,,,,     | No  | (If yes, give wor or dates of                             |                               | Unknown                    | Be       | ertha W.                                | Jer       | nnings                 | -Same                         | Item      | 1 #2        |                     |               |
|          | 18. CAUSE OF DEA  | TH WAS CAUSED BY:   | (0)                           | ne for (o), (b), and (c).] | RI       | DIAL                                    |           | INF                    | ARC7                          | ion       |             | ERVAL BE<br>SET AND |               |
|          | Conditions, if o  | DUE To<br>ny, which )                                     | 0                             |                            |          |   |           |                        |                               |           | 114.0       |                     |               |
|          | gove rise to i couse (o), stoting                         | mmediote DUE T  | 0                             |                            |          | 2072                                    |           |                        |                               |           |             |                     |               |
| _        | lying couse lost.   | )   | (c)                           |                            |          |   |           |                        |                               |           |             |                     |               |
| CATION   | PART II. OTH  | ier significant coi                                       | NDITIONS (                    | ON E                       | TH BUT N | OT RELATED TO T                         | HETERM    | INAL DISEASE           | CONDITION G                   | IVEN IN   | PART 1(o)   | PERFO<br>YES        | RMED?         |
| CERTIFIE | 20a. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)            | 20b. DES                      | CRIBE HOW INJURY OC        | CURRED.  | (Enter nature of                        | injury in | Port I or Port         | II of item 18.)               |           |             |                     | bei           |
| MEDICAL  | 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.                 | Y Month, Doy, Y   | ear 20d. I<br>While<br>of wor | Not while                  |          | E OF INJURY (He<br>ry, street, office b |           |                        | or town)                      |           | (County)    |                     | (Stote)       |
|          | 21. I certify th  | at I attended th  | e deceas                      | ed fram Jan                | ·        | 19.59,                                  | ta        | 9/10                   | 19.2                          | 7,that    | I last say  | w the d             | le ce a sed   |
|          | alive an  | 9/10 ly Dr. 4   | illia                         | 29, and that on Howell     | death o  | 9/10/59                                 | 321       |                        | the causes o                  |           | the date    |                     | d abave.      |
|          | ACTUAL<br>SIGNATURE                                       | Cdwa  | dw.                           | younghlo                   | M.       | D. Was                                  | ling      | ten c                  | livie                         | Wo        | 1.15        |                     | 7/12/3        |
|          | PHYSICIAN'S E   | dward W.  | Your                          | gblood, M.                 | D.       |   |           |                        |                               |           |             |                     |               |
| 220      | BURIAL, CREMATIC  | N, 22b. DATE THERE  | OF                            | 22c. NAME OF CEMET         | ERY OR   | CREMATORY                               | 7         | 22d. LOCAT             | ION (City, town               | , or cour | nty)        | (Stot               | le)           |
| C        | remation  | 9/14/19   | 59                            | Cedar Hi                   |          |   | У         |                        | nce Geo                       | rge       | s M         | aryl                | and           |
|          | obert A   |   | Ret                           | ADDRESS<br>hesda. Mary     | vlano    |   |           | D BY REGISTI           |                               |           | S SIGNATU   |                     |               |

the haspital or ottending physician.

TOR: After this certificate has been signed by the ottending physician and campletely filled in by rife funeral director, the haspital are serificate has been signed by the ottending physician papers. Pages I and 2 should be filed with ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. the registrar prior to burial, cremation, or remaval, and in ony event within 72 hours after eath. may be retain TO FUNERAL D VS A15 (4) 15M 9/5B

death. Page 4

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All T. M. Dordenstein, W. Leitwick, M. T. W. Commission of the Com

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| ter deoth. If ony delay is necessory, please exe-   | and 3 to the funeral div. Poge 4 should be                         | be retoined for your file                                       | of 2 with the registrar priar to burial, cremotion,   |  |
|---|--|---|---|--|
| TO DEPUTY MEDICAL EXAMINER: This certificate shauld be executed within 24 hours offer death. If any delay is necessory, please exe- | riting the word "pending" in pencil in Item 18. Give Pages 1, 2, o | if Medical Examiner's Office along with farm PM3. Page 5 may be | TO FUNERAL EXECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, |  |
| TO DEPUTY MEDICAL   | cute the certificate, v  | forworded e Chi   | TO FUNERAL ELECTO   |  |

VS. A15ME(S) 5M 9/55

|    | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |   |  |  |  |  |  |
|----|--|---|--|--|--|--|--|
| \$ | MEDICAL EXAMINER'S   | S CERTIFICATE OF DEATH  |  |  |  |  |  |
|    | 1. PLACE OF DEATH O. COUNTY  MARYLAND  | Reg. Dist. No.  2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission)  o. STATE  b. COUNTY  b. COUNTY |  |  |  |  |  |
|    | b. CITY OR TOWN (If outside corperors limits, write RURA) c. LENGTH OF STAY IN 1b and give nearest lown)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |  |  |  |  |
|    | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  8 600 Manchester Rel   | /d. STREET ADDRESS  6. IS RESIDENCE ON A FARM? YES   NO   |  |  |  |  |  |
|    | 3. NAME OF DECEASED (Type or print) Estelle Calin Oera   | Last 4. DATE Month Day Year OF DEATH DEATH DIST   |  |  |  |  |  |
|    | 5. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.  Whate WIDOWED DIVORCED 1   | DATE OF BIRTH  9. AGE (In years)  15 UNDER 1YEAR IF UNDER 24 HRS.  Months Days Hours Min.   |  |  |  |  |  |
| )  | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUST dyring most of working life, even if retired)  | 11/ BIRTHPLACE (Stote or foreign country)  12. CITIZEN OF WHAT COUNTRY?  M.S.Q.   |  |  |  |  |  |
|    | 13. FATHER'S NAME Sullian aidt   | amelea Miller   |  |  |  |  |  |
|    | 1S. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no., or unknown) (If yes, give wor or doles of service) 27  | male levelanos 2009 starter st ned  |  |  |  |  |  |
|    | 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), ond (c).]  PART I. DEATH WAS CAUSED BY:  MMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse last.  | smoke & Junes home  |  |  |  |  |  |
| )  | CCATIC   | IOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART J(a) 19. WAS AUTOPSY PERFORMED?  YES NO 1                                 |  |  |  |  |  |
|    |  | nter nature af injury in Port 1 or Part II of item 18.)   |  |  |  |  |  |
| 5  | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while foctor of work of work of work   | CE OF INJURY (Home, form, 20f. (City or town) (County) (State)  ry, street, office bldg., etc.)  Librar Sping Mitty med               |  |  |  |  |  |
|    | 21. I certify that I took charge of the remains described about death resulted fram: Natural causes, Accident, Suice   | ve, held an Autapsy [], Inspection [2], Inquiry [2], and find that cide [], Hamicide [], Undetermined cause [].                       |  |  |  |  |  |
| 7  | SIGNATURE Frank J. Botschart   | _M.D. CHIEF MEDICAL EXAMINER   DATE SIGNED  |  |  |  |  |  |
| *  | EXAMINER'S FLANK T. Broschart  | ASSISTANT MEDICAL EXAMINER 9-21-59  DEPUTY MEDICAL EXAMINER 9   |  |  |  |  |  |
|    | 220. BURIAL CREMATION, 22b. DATE THEREOF 22c, NAME OF CEMETERY OR SET 24, 959 How Rudelenia 23 Monter Author Office of Communication of Commun | Cemitry Ballimon, Marylon   |  |  |  |  |  |
|    | 254 CARROLL ST. N.L  | 12, D. C. 740. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 10. DATES P. 2. 3 '59 Called & Hand                                      |  |  |  |  |  |

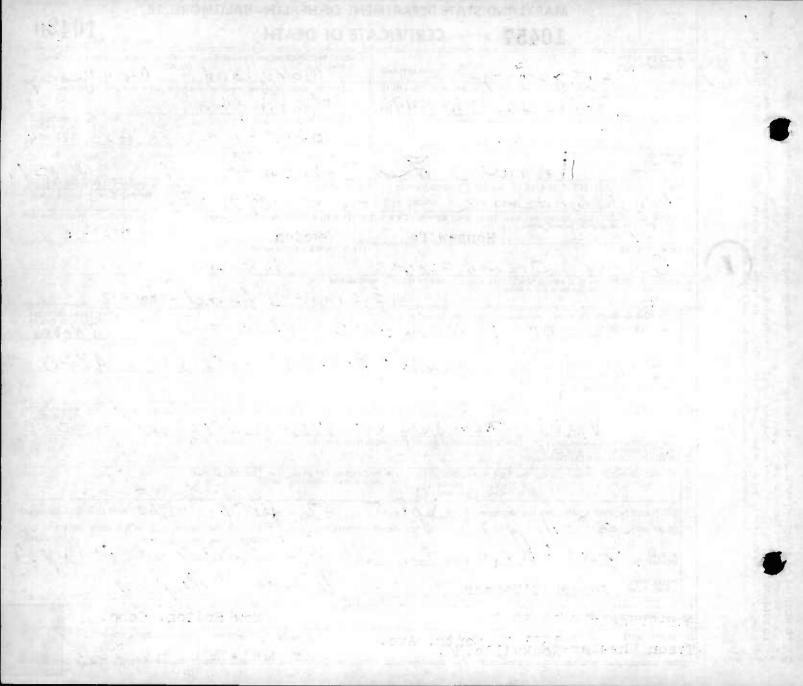
Enthance of the State of

| 10456   | CERTIFICA   | ATE OF DEATH  |                           |                | Reg. Dist. I               | No.          | 20                        |  |
|---|---|---|---------------------------|----------------|----------------------------|--------------|---------------------------|--|
| n. PLACE OF DEATH<br>o. COUNTY<br>Montgomery  | MARYLAND  | 2. USUAL RESIDENCE (Who o. SLATE Maryland                       |                           |                | n: Residence b<br>tgo. ery | efore odmiss | ion)                      |  |
| b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) Bethesda   | c. LENGTH OF STAY IN 16                           | c. CITY OR TOWN (If o   |                           | nits, write RU | JRAL and give              | nearest town | )                         |  |
| d. NAME OF HOSPITAL (If not in hospitol, give street or institution Suburban Hospital   | address)  | d. STREET ADDRESS   | ick R ad                  |                |                            |              | IDENCE<br>FARM?<br>NO [3] |  |
| NAME OF DECEASED (Type or print) George Edward  | Middle<br>Jetter                                  | Lost  | 4. DATE<br>OF<br>DEATH    | Sept.          |                            | -,           | Yeor<br>1959              |  |
| SEX 6. COLOR OR RACE 7. MARR WIDOWE   |   | B. DATE OF BIRTH 10/19/78 79                                    | 9. AG<br>lost<br>79 8     | birthday)      | Manths Day                 | _            | R 24 HRS<br>Min.          |  |
| during most of working life, even if retired)  SAXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  | KIND OF BUSINESS OR INDU<br>LARKUM CO<br>TNIMEXKY | ISTRY 11. BIRTHPLACE (State New You                             | ar fareign cauntry)<br>rk |                |                            | . S:         | OUNTRY                    |  |
| FATHER'S NAME   |   | 14. MOTHER'S MAIDEN N   | IAME                      |                |                            |              |                           |  |
| Edward Jetter   |   | E. Nunn   |                           |                |                            |              |                           |  |
| , WAS DECEASED EVER IN U. S. ARMED FORCES? 16.  | SOCIAL SECURITY NO.                               | INFORMANT   |                           | Addr           | ess                        | 100          |                           |  |
|   | 71-05-1831 E                                      | leanor Jetter.  | , 11707 B                 | erwick         | c. Silv                    | er Spr       | ing.                      |  |
| Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | m-spent   | in prosto   | tectm                     | 0              | ENLINE DA DT 1/2           | 110 MAC      | ALITOREY                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part II or Part II of item 18.) |   |   |                           |                |                            |              |                           |  |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |                           |                |                            |              |                           |  |
| 20c. TIME OF INJURY Month, Doy, Year 20d. IN Hour o. m. While ot worl   | Not while fo                                      | ACE OF INJURY (Hame, farm<br>actory, street, office bldg., etc. |                           | vn)            | (Cour                      | nty)         | (State                    |  |
| 21. I certify that I attended the deceased from   |   |   |                           |                |                            |              |                           |  |
| PHYSICIAN'S A STUDE   | LETS  | MD. GOG PE  | RSHING                    | DR             | WE.                        | 6 4          |                           |  |
| PAME (Type) PATHUS 3. 37  Pas Burial, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) RANS & BURIAL 9/5/59   | 22c. NAME OF CEMETERY C                           |   | 22d. LOCATION (I          | City, town, o  | or county)                 | (Stot        | e)                        |  |
| 3. FUNERAL DIRECTOR'S SIGNATURE WARNER ENDOWNER LANG.   | STLVER SPRIN                                      | G, MD. 24a. REC'I   | D BY REGISTRAR            | 20000000000    | TRAR'S SIGNA               |              |                           |  |

TO FUNERAL D COR. After this certificate has been signed by the attending physician and campletely filled in by me funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon pages. Pages 1 and 2 should be filed with r death. Page 4 M TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs the registrar priar ta burial, crematian, ar remaval, and in any event within 72 haurs after death

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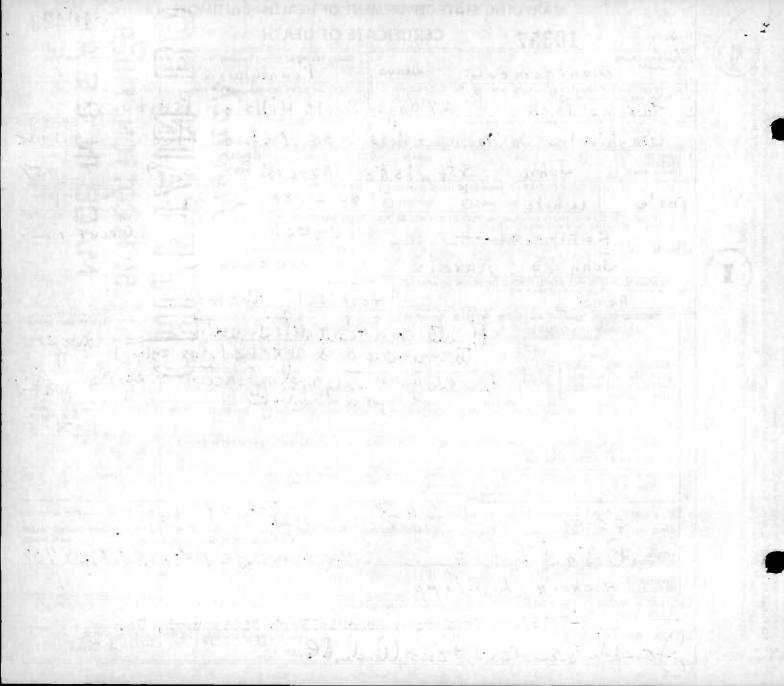
(State)

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. COUNTY b. COUNTY M ontg. o. STATE Marvland MARYLAND Montgomerv b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Gaithersburg Gaithersburg e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 6 Russell Ave. 6 Russell Ave YES NO P 3. NAME OF First Middle DATE Month Lost Day Year DECEASED OF DEATH 19, 1959 Harold Sherwood Kingslev Sept (Type or print) 19 9. AGE Iln years 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS. Months Days Hours Min. 82 8/2/1877 WIDOWED TH DIVORCED T male white yrs. 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) USA carpenter Mass 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Elbridge Kingsley Fannie Sherwood 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) If yes, give war or dates of service Item 2 Clarice Griffith (daughter) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Coronary occlusion sudden IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause DUF TO (o), stoting the underlying couse fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? YES T NO E 20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, 20d. INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, office bldg., etc.) o. m. Not white of work at work p. m. 21. I certify that I taak charge of the remains described above, held an Autapsy , Inspection . Inquiry . and find that death resulted from: Natural causes , Accident , Suicide . Hamicide , Undetermined cause . DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER **EXAMINER'S** 9/19/59 Frank J. Broschart DEPUTY MEDICAL EXAMINER NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) ADDRESS 23, FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR Colling & Tracks

VS. A15ME(S) 5M 9/55

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Reg. Dist. No. 215

| PLACE OF DEATH     O. COUNTY   |                                     |               |                        | - 11 6     | JSUAL RESIDENCE<br>S. STATE            | (Where decease     | d lived. If instituti<br>b. COUNTY |  | before odm   | issian)             |
|--|-------------------------------------|---------------|------------------------|------------|--|--------------------|------------------------------------|--|--------------|---------------------|
| Montgom  |                                     |               | MARYLA                 | ND         | Marylar                                | nd                 | 70.00                              | ontgom   | ery          |                     |
| b. CITY OR TOWN (If our RURAL and give neares                                    |                                     | s, write c.   | LENGTH OF STAY IN      | 1b         | . CITY OR TOWN                         | (If autside corpo  | prote limits, write R              | URAL ond giv   | e nearest to | wn)                 |
| Bethesda   | 1-                                  | )             | 8½ hour                | s 26       | Rockvil                                | lle                |                                    |  | 53.0         |                     |
| d. NAME OF HOSPITAL ( OR INSTITUTION   | f not in hospital, gi               | ve street add | lress)                 | - 1        | d. STREET ADDRES                       | S                  |                                    | Thos.  | e. IS R      | ESIDENCE<br>A FARM? |
| U.S. Nava  | 1 Hospi                             | tal,          | Bethesda               | , Md       | 1109 Le                                | ewis Av            | renue                              |  |              | □ NO □X             |
| 3. NAME OF<br>DECEASED   | Firs                                | r             | Middle                 |            | Lost                                   | 4. DATE            | Mor                                | ıth  | Day          | Year                |
| (Type or print)  | Cece                                | lia           | Irene                  |            | KOVARIA                                | OF DEATH           | Sept                               | tember   | 26           | 19 59               |
| 5. SEX   6.  | COLOR OR RACE                       | 7. MARRIED    | NEVER MARRIED          | B. DA      | TE OF BIRTH                            | 73.11              | 9. AGE (In years                   | The second secon |              | DER 24 HRS.         |
| Female   | White                               | WIDOWED       | DIVORCED [             | 5          | 9-25-59                                | 9                  | lost birthdoy)<br>yrs.             | Manths D   | ays Hou      | 7 Min.              |
| 10o. USUAL OCCUPATION ( during most af working                                   | Give kind of work d                 | one 10b. KIN  | D OF BUSINESS OR       | NDUSTRY    | 11. BIRTHPLACE (S                      | itate or foreign c | auntry)                            | 12. CITIZE   | N OF WHA     | T COUNTRY?          |
| None   |                                     | No            | ne                     |            | Mary                                   | vland              |                                    | T  | LS.A         |                     |
| 13. FATHER'S NAME  |                                     |               |                        | 14         | MOTHER'S MAID                          | EN NAME            |                                    |  |              |                     |
| Clifford   | Vincent                             | KOVA          | RIK                    |            | Juanit                                 | ta Joar            | ne GOV                             | JAI  |              |                     |
| 15. WAS DECEASED EVER IN   |                                     | ES? 16. SO    |                        | INFOR      | MANT                                   |                    | Add                                | ress   |              |                     |
| No   | , give war ar agree or se           |               | None                   | Cli        | ford Vi                                | incent             | KOVARIE                            | Same   | as           | 2d                  |
| 18. CAUSE OF DEATH   | Enter only one cou                  | se per line f | or (a), (b), and (c).] |            |  |                    |                                    |  | INTERVAL     |                     |
| PART I. DEATH V  | VAS CAUSED BY:<br>MEDIATE CAUSE (a) | (             | Imea                   | 1123       |  |                    |                                    | E 50   | ONSET AN     | MIN                 |
| 776×   | 776 × DUE TO                        |               |                        |            |  |                    |                                    |  |              |                     |
| Conditions, if any,  | which )                             | 1             | Proma                  | Tuni       | 7                                      |                    |                                    |  | RI           | Lower               |
| gove rise to imme  | diate (DUE TO                       |               | - Corrica              |            | 2                                      |                    |                                    |  |              |                     |
| lying cause last.  | under-                              |               |                        |            |  |                    |                                    |  |              |                     |
|  | IGNIFICANT COND                     | ITIONS CON    | TRIBUTING TO DEATH     | H BUT NOT  | RELATED TO THE T                       | ERMINAL DISEAS     | E CONDITION GIV                    | VEN IN PART I  | (a) 19. WA   | S AUTOPSY           |
| PART II. OTHER S  20a. ACCIDENT WAS UI OR CONTRIBUTING [] (IF EITHER, NOTIFY MED |                                     |               |                        |            |  |                    |                                    |  | PER<br>YES   | FORMED?             |
| 20a. ACCIDENT WAS U  | NDERLYING [                         | 20b. DESCRIE  | BE HOW INJURY OCC      | URRED. (Er | ter noture of injury                   | y in Part I or Por | t    of item 1B.)                  |  |              | And,                |
|  | CAUSE OF DEATH                      |               |                        |            |  |                    |                                    |  |              |                     |
| 20c. TIME OF INJURY A<br>Haur a. m.<br>p. m.                                     | Aonth, Day, Yea                     |               |                        |            | OF INJURY (Hame, street, office bldg., |                    | or town)                           | (Car   | unty)        | (State)             |
| Haur a.m.  | 19                                  | While of work | Not while of work      | ,,         | silves, ettice bidg.,                  | , 6.6.,            |                                    |  |              |                     |
| 21. I certify that   | attended the                        | deceased      | fram 25 Se             | ept        | 1959 to                                | 26. Ser            | 12.55                              | that I last  | saw the      | deceased            |
| alive an 26 S  |                                     | 19 59         |                        |            | urrad at 7 · 3                         | 30 4 6             | the course on                      | d an the   | data stat    | ad abava            |
| dive dil   | 3/                                  | -1 1-11       | , and mar d            | ウ          | oned division                          |                    | treet, city or town,               |  |              | ATE SIGNED          |
| ACTUAL   | 10000                               | 11            | 2/8                    | 01.        | II.S I                                 |                    | Hospital                           |  | hesd         | a.Md                |
| SIGNATURE  | 3000                                | un            | 700                    | M.D.       |  | 100 100 1          |                                    | . )  |              | 26-59               |
| PHYSICIAN'S<br>NAME (Type)   | .W. SE                              | LL LT         | MC USN                 | 1          | J.S. Na                                | val Hos            | spital,                            | Bethe  |              |                     |
| 220. BURIAL, CREMATION,  |                                     |               | 2c. NAME OF CEMETE     | RY OR CRE  | MATORY                                 | 22d. LOCA          | TION (City, town,                  | or caunty)   | (5           | tote)               |
| REMOVAL (Specify) Burial   | 9-28-5                              |               | Gate of                |            |  |                    | lver Spi                           |  | Md.          |                     |
| 23. FUNERAL DIRECTOR'S SIG   | GNATURE R                           | ockvi         | 14Pers Mar             |            |  | REC'D BY REGIS     | -                                  | STRAR'S SIGN   | ATURE        |                     |
| Tyson Whe  | 1 30                                |               | Montgom                |            |  | SEP 3.0            | 59                                 | alles 2  | Homes        |                     |

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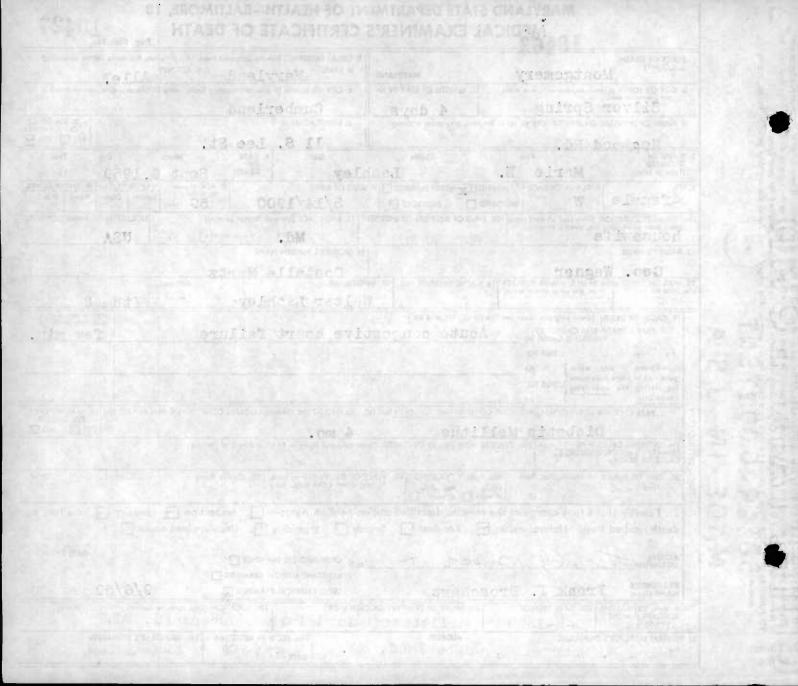
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|          |  |  |               | STATE DEPARTM                        |   |                        |  | 18                | 40401                                      |
|----------|--|--|---------------|--------------------------------------|---|------------------------|--|-------------------|--|
|          |  | 1048   | DICA          | L EXAMINER'S                         | CERTIF                                    | ICATE OF               | DEATH                                  | Reg. Dist. N      | 1.0421                                     |
| 7.       | PLACE OF DEATH<br>o. COUNTY                                  | Montgomer  | У             | MARYLAND                             | 2. USUAL RESID                            | Marylan                | b. COUN                                |                   | efare admission)                           |
|          | and give nearest to  |  | e RURAL       | c. LENGTH OF STAY IN 1b              |   | OWN (If autside co     |  | e RURAL and give  | nearest town)                              |
| -        |  | er Spring  | If not in hos | spital, give street address)         | d. STREET AD                              | mberlan                | <b>a</b>                               | 0102              | e. IS RESIDENCE<br>ON A FARM?              |
| 3.       | NO PWO   | ood Rd.  | st .          | Middle                               | Lost                                      | S. Lee                 | St al                                  | nth Day           | YES NO Year                                |
|          | (Type or print)  | Marie  | E.            | Las                                  | hley                                      | OF<br>DEATH            |  | 6.1959            | 19   |
| 5.       | female   | 6. COLOR OR RACE   | 7. MARRII     | ED NEVER MARRIED 8                   | DATE OF SIRTH                             | /1900                  | 9. AGE (In years last birthday) 59 yrs | Months Days       | Hours Min.                                 |
| 10       | during most of wood housewi                                  | king life, even if refired)  | dane 10b. I   | Own Home                             |   |                        | country) berland                       |                   | OF WHAT COUNTR                             |
| 1:       | 3. FATHER'S NAME   | DATE OF STREET   | 3 - 3         | Own Home                             | 14. MOTHER'S M                            |                        | 001 20110                              | - TOOR            |  |
|          |  | Wagner<br>EVER IN U. S. ARMED FO   | RCES? 16.     | SOCIAL SECURITY NO. 17. II           | Cost                                      | elle Ma                | rt.z.                                  | 15                |  |
| (,       | 'es, no, or unknown)   | (If yes, give wor or dates of  | service)      |                                      | Walter :                                  | Lashley                |  | Item              | 2.   |
|          |  | ATH [Enter only one can<br>ATH WAS CAUSED 8Y:<br>IMMEDIATE CAUSE (o)<br>DUE TO | 1             | for (o), (b), ond (c).] Acute conges | tive he                                   | art fai                | lure                                   |                   | erval between<br>set and death<br>cew min: |
|          | Canditians, if gave rise to imm (a), stating the cause last. | ony, which (b)   |               |                                      |   |                        |  |                   |  |
| CATION   | ) ]  | THER SIGNIFICANT CON   | _             | ONTRIBUTING TO DEATH BUT I           | 4 mo                                      | HE TERMINAL DISEA      | SE CONDITION G                         | IVEN IN PART 1(0) | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO X  |
| CERTIEIC |  | AUSE WAS   |               | E HOW INJURY OCCURRED. (E            |   | ry in Port I or Port I | l of item 18.)                         |                   |  |
| MEDICAL  | 20c. TIME OF INJ   | 1.   | While         |                                      | CE OF INJURY (Ho<br>pry, street, office b |                        | ty or town)                            | (County)          | (State)                                    |
|          | 21. I certify  | that I taok charge   | of the        | remains described abo                | ve, held an A                             | Autopsy ,              | Inspection 🗔                           | Inquiry 5         | , and find th                              |
|          | death resulte  | d from: Natural  | causes 5      | , Accident , Sui                     | cide 🔲, Ho                                | micide 🔲, L            | Indetermined                           | cause .           |  |
|          | ACTUAL SIGNATURE   | Frank J.   | Bu            | schart                               | _M.D.                                     | DICAL EXAMINER         |  |                   | DATE SIGNED                                |
| 2        | EXAMINER'S<br>NAME (Type)                                    | Frank J.   |               | schart                               |   | EDICAL EXAMINER        | _                                      | 9/6/59            |  |
| 2        | REMOVAL (Species Burial                                      | 10N, 22b. DATE THEREC  | 59            | 22c. NAME OF CEMETERY OR Hillcrest   |   |                        | ation (City, town,<br>umberlar         | 75 TO 175 TH      | (Stote)                                    |
| 23       | James  | F. Scarpel   | li,           | Cumberland,                          | 70  | 40. REC'D BY REGIS     |  | oistrar's signatu |  |



ter death. Page ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 how

by the haspital ar attending physician.

CTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral directar, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers, the registrar prior to buriol, cremation, ar remayal, and in any event within 72 hours after death. TO FUNERAL E

TO HOSPITAL

VS A15 (4) 15M 9/5B

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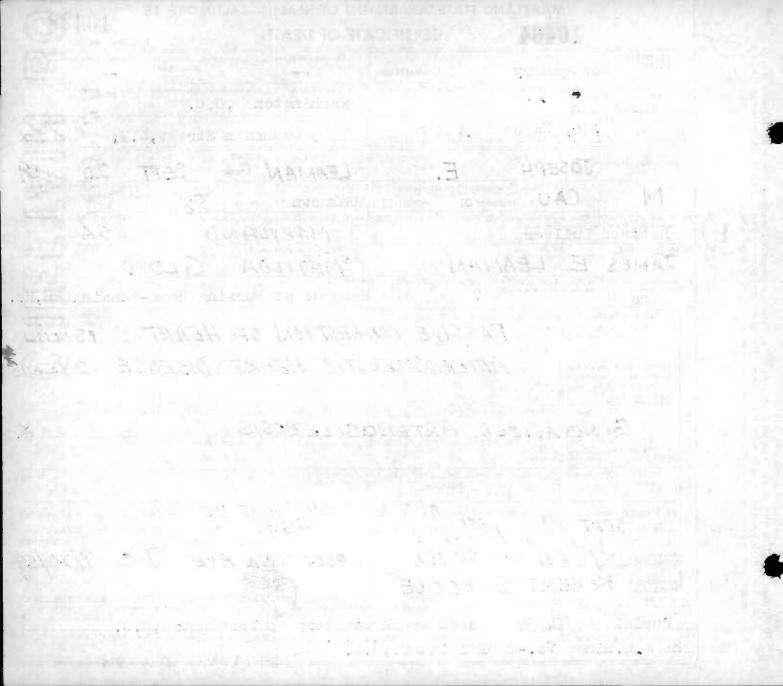
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10464

### **CERTIFICATE OF DEATH**

10428

Reg. Dist. No

|               | PLACE OF DEATH  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY   |  |  |  |  |  |
|---------------|---|--|--|--|--|--|--|
| -             | b. CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)   |  |  |  |  |  |
|               | RURAL ond give nearest fown) Kensington   | Washington ,D.C. 47x-3   |  |  |  |  |  |
| F             | d. NAME OF HOSPITAL (If not in baspitol, give street oddress) OR INSTITUTION ROOF MCCOMAS Avenue ensing ton Gardens Nursing Home  | d. STREET ADDRESS 1409 Buchanan Street, N.W. C. IS RESIDENCE ON A FARM? YES \( \) NO   |  |  |  |  |  |
|               | NAME OF DECEASED (Type or print)  NAME OF DECEASED (Type or print)  Middle  | LEAMAN 4. DATE OF Day Year Day 19 59   |  |  |  |  |  |
| 5.            | 6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   WIDOWED   | B. DATE OF BIRTH  9. AGE (In years life UNDER 1 YEAR IF UNDER 24 HRS.  White Indian is the state of the state |  |  |  |  |  |
| 100           | b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Retired Builder  | USTRY 11. BIRTHPLACE (State or foreign country)  MARYLAND  12. CITIZEN OF WHAT COUNTRY?  USA.  |  |  |  |  |  |
| 13.           | JAMES E, LEAMAN.  | HATILDA GLOYD.   |  |  |  |  |  |
|               | WAS DECEASEDEVER IN U. S. ARMED FORCES? a, no, or unknown) (If yes, give war or dates of service)   | Records at Nursing Home-Kensington, Md   |  |  |  |  |  |
|               | 4.20.0 DUE TO   | NGESTION OF HEART INTERVAL BETWEEN ONSET AND DEATH ISMINI ROTIC HEART DISEASE 10 YEAR  |  |  |  |  |  |
| CERTIFICATION | GENERALIZED ARTER   | TO NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  VES NO PORT I OF PORT II OF ITEM 18.)  |  |  |  |  |  |
| MEDICAL       |   | PLACE OF INJURY (Hame, farm, octory, street, office bldg., etc.) (City or town) (County) (State)   |  |  |  |  |  |
|               | ACTUAL SIGNATURE KANNESS STOOLE   | th accurred at 4.53 pm, from the causes and an the date stated abave.  ADDRESS (Street, city or town, state)  M.D. 4501 CONN AVE D.C. 9/20/59  |  |  |  |  |  |
|               | PHYSICIAN'S NAME (Type) ROBERT S. POOLE   | 43   |  |  |  |  |  |
| 23.           | Burial (Specify)  Burial 9/21/59  FUNERAL DIRECTOR'S SIGNATURE  POR S.H. Hines Co2901  POR NAME OF CEMETERY  ROCK Creek  ADDRESS Wash  Co2901  POR NAME OF CEMETERY  ROCK Creek  ADDRESS Wash  Co2901 | Ceme tery Washing ton D. C. 1. D. C. 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE  |  |  |  |  |  |



TO ATTENDIL

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10429

## 10358 CERTIFICATE OF DEATH

Reg. Dist. No.....

|           | 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (HOME) OF DECEASED   |
|-----------|--|---|
|           | COUNTY MONTGOINEY MARYLAND   | STATE Mary and county Montgomery  |
|           | CITY (If outside corporate limits, wate RURAL ARCH OF STAY (in this plece)   | CITY (If outside corporate limits, write RURAL end give neerest tovin) OR |
|           | 19140M3 1011   | 1 CKOWA I QYK   |
| <         | HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 - Albany Ave.  | / STREET (1 rurel give location) ADDRESS 517- AID any Ave.  |
|           | 3. NAME OF (First) (Middle)  | (Lest) 4. DATE (Mohth) (Dey) (Yeer)   |
|           | (Type or Print) LUCY RESECCA LI  | EECH DEATH SEPT. 30, 19 59  |
| -         | 5. SEX 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF WIDOWED, DIVORCED,   | Months   Days   Hours   Min   |
| 1         | Temale white Specify Widow NOV:  | 20, 1875   83 yrs. 10 10 mm   |
| A         |  | I. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?  |
| -         | done during most of working life even if OR INDUSTRY refired)  | Washington, D.C. Visa.  |
|           | 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
|           | Ephriam Carlos Merriam   | Helen Wirt White  |
|           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.   | 17. INFORMANT & ADDRESS NEPHEN  |
|           | (Yes, no, or unk.) (If Yes, give war or dates of service)  | 11m Linville - Schenectedy, N.Y.  |
|           | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   | INTERVAL BETWEEN ONSET AND DEATH  |
|           | 4500 IMMEDIATE CAUSE (A) Composter   | " Heart tailure I day   |
|           |  | 0 1 2   |
|           | DISEASES OR CONDITIONS, IF ANY, (B)  | selerosir indiput   |
|           | GIVING RISE TO THE ABOVE CAUSE<br>STATING UNDERLYING CAUSE LAST, DUE TO  |   |
|           | (C)  |   |
| A         | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE   |   |
| 0         | DISEASE OR CONDITION CAUSING DEATH.  |   |
| 9         | 196. DATE OF OPERATION 196. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? YES NO   |
|           | 21e. ACCIDENT WAS UNDERLYING ☐ 21b. PLACE (Home, farm, factory, OR CONTRIBUTING ☐ CAUSE OF DEATH OF INJURY street, office bidg., etc.)  (IF EITHER, NOTIFY MEDICAL EXAMINER) | :. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |
|           | 21d. TIME OF INJURY (Month) (Dey) (Yeer) (Hour) 21e. INJURY OCCURRED 21 While Not while M. et work et work   | f. HOW DID INJURY OCCUR?  |
|           | 3  | 105-3 1/1. H 30 10 178 Hall I am the  |
| 1         | 22. I hereby certify that I attended the deceased from   |   |
| ~         | alive on 31, 30, 19, and that death occurred at  | ADDRESS (Street, city, town, stete)  DATE SIGNED  |
| 10M       | 15   | 11 1-7 / 11/1 1.2 / 12 8/21   |
| 1-55      | 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR C  | REMATORY   LOCATION (City, town, or county) (State)   |
| A15C 1-55 | BURLAL 10/5/1959 ARLINGTON NA  | TIONAL CHMETERY ARLINGTON, VIRGINIA   |
| S         | 24. REC'D BY REGISTRAR   REGISTRAR'S SIGNATURE   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  |
|           | DATE OCT 5 2 '59 Clothur & Home  | martin W. Hypong 60 Wash, V.C.  |
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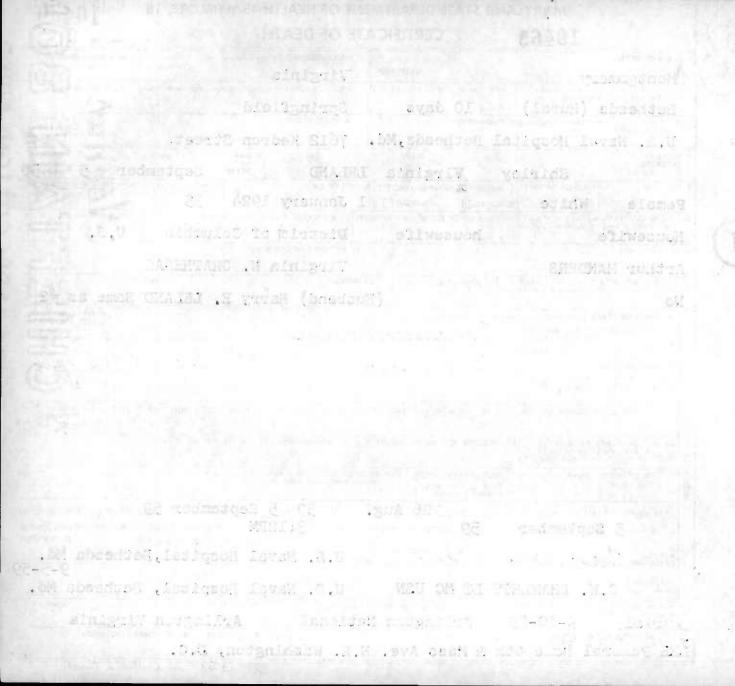
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| CERTIFICATE OF DEAT |  |
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|  | 101.0  | CERT                                 | IFICATE OF E   | DEATH   |  | Reg. Dis   | st. No.         | 215   |
|--|--|--------------------------------------|--|---|--|--|-----------------|---|
| D. PLACE OF DEATH O. COUNTY MONTGON  | ery  | MAR                                  | 2. USUAL RESI  |   | eceased lived. If inst<br>b. COU   |  | ce befare a     | dmission)                                     |
| b. CITY OR TOWN<br>RURAL and give  | (If autside carporate limits                                 | , write c. LENGTH OF STAY            | ' IN 1b c. CITY OR   | TOWN (If autside                                | carporate limits, wri  | ite RURAL and g                                      | give negrest    | tawn)   |
| Betheso  |  | 9 days                               | Lexin  | ngton P   | ark  | 18X  | - de            |   |
| d. NAME OF HOSP  | TAL (If not in haspital, giv                                 | ve street address)                   | d. STREET A  |   |  |  |                 | RESIDENCE                                     |
|  | Vaval Hosp   | ital                                 | 16 Ma  | dison   | Ave.   |  |                 | S NO  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First  | Middle<br>ietta                      |  | 4. D  | ATE<br>OF  | Month<br>tember                                      | Day             | Year<br>19 59                                 |
| S. SEX   |  | 7. MARRIED NEVER MARR                |  |   | 9. AGE (In ye  | ears IF UNDER  | 1 YEAR IF L     | JNDER 24 HR                                   |
| Female   |  | WIDOWED DIVORCE                      |  | -11   | last birthdo   | yrs. Months  | Days H          | ours Min.                                     |
|  |  | one 10b. KIND OF BUSINESS            |  |   |  |  | ZEN OF WH       | AT COUNTRY                                    |
| Housewil   |  |                                      | - Ged  | orgia   |  | I  | J.S.A           |   |
| 3. FATHER'S NAME   |  |                                      |  | MAIDEN NAME                                     |  |  |                 |   |
| Thomas !   | PROUTMAN   |                                      | Geo  | rgia LA   | UREL   |  |                 |   |
| S. WAS DECEASED EV   | ER IN U. S. ARMED FORC                                       | ES? 16. SOCIAL SECURITY NO           |  |   |  | Address  | 100             |   |
| No (Yes, no, or unknown)   | (If yes, give wor or dates of ser                            | VICE)                                | Hospita:   | l Recor   | ds   |  |                 |   |
|  | ATH [Enter anly ane cau                                      | se per line far (a), (b), and (c)    | .]   | 1   |  |  | INTERV          | L SETWEEN                                     |
| PART I. DE   | ATH WAS CAUSED 8Y:   | Cardia                               | e arrest   |   |  |  |                 | AND DEATH                                     |
| 518×   | DUE TO   | ,                                    |  |   | Water Street   |  |                 |   |
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| gave rise to   | immediate (  |                                      |  | - 1/  | atelect  | FASIS of   |                 |   |
| lying cause last   | the under-   | Broncho-                             | Pleural F  | 15 tula   | + Rt. Low  | ren Lobo   | 3               |   |
| PART II. OT  | _ / (0).   | OITIONS CONTRIBUTING TO DI           | EATH BUT NOT RELATED TO  | O THE TERMINAL D                                | DISEASE CONDITION  | I GIVEN IN PAR                                       | P               | VAS AUTOPS'<br>ERFORMED?<br>S NO [            |
| OR CONTRIBUTION  | AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)               | 20b. DESCRIBE HOW INJURY (           | OCCURRED. (Enter nature o  | of injury in Part 1                             | ar Part II af item 18  | .)   |                 |   |
| Z 20c. TIME OF INJU  |  |                                      | 20e. PLACE OF INJURY factory, street, affic                            |   | f. (City ar tawn)  | (0   | Caunty)         | (Stat   |
| Hour a.m.  | 19   | While Nat while at wark at wark      |  | e blog., etc.)                                  | 323 (-) 7  |  |                 |   |
| Hour a.m.  | 19   | deceased from Sep1                   | t. 2 19 50   | 9 to Sep  | t. 11, 19  | 29,that I lo   | ast saw tl      | ne decease                                    |
| Hour a.m.  | hat I attended the   | deceased from Sep1                   | t. 2 19 50   | 9 to Sep  | t. 11, 15  | 9,that I lo  | ast saw tl      | ne deceas                                     |
| P. m.  | hat I attended the   | deceased from Sep1                   |  | 9, to Sep<br>2:05M,                             | M<br>fram the causes<br>ESS (Street, city or to                                      | and an the   | e date st       | DATE SIGN                                     |
| 21. I certify talive an S  | hat I attended the   | deceased from Sep1                   | t. 2 19 50   | 9, to Sep<br>2:05M, f                           | M<br>ram the causes  | and an the   | e date st       | DATE SIGN                                     |
| 21. I certify t  | hat I attended the ept. 11                                   | deceased from Sep1                   | t 2 19 59<br>t death accurred at                                       | 9, to Sep<br>2:05MP<br>ADDR<br>S. Nav           | M<br>fram the causes<br>ESS (Street, city or to                                      | s and an the<br>own, state)<br>Ltal                  | e date st       | ated abay                                     |
| 21. I certify t alive an Signature  PHYSICIAN'S NAME (Type)  220. BURIAL, CREMATI  | hat I attended the ept. 11  R. G. MUT  ON, 22b. DATE THEREOF | deceased from Sept., 19 59 , and tha | t 2 19 59<br>t death accurred at                                       | 9, to Sep<br>2:05M,<br>ADDR<br>S. Nav           | m the causes ESS (Street, city or to al Heep!  | s and an the<br>own, state)<br>Ital                  | e date st       | ne decease ated abay DATE SIGNI 12-59 (State) |
| 21. I certify t alive an Signature  PHYSICIAN'S NAME (Type)  220. BURIAL, CREMATI  | hat I attended the ept. 11  R. G. MUT                        | deceased from Sept., 19 59 , and tha | t. 2 , 19 50 t death accurred at  M.D. U.  USN Be                      | 9, to Sep<br>2:05M,<br>ADDR<br>S. Nav<br>thesda | m the causes ESS (Street, city or to al Heep 1                                       | s and an the awn, state) Ital  /land  wn, or county) | e date st       | DATE SIGN<br>12-59<br>(State)                 |
| 21. I certify to alive an Standard Signature  PHYSICIAN'S NAME (Type)  220. BURIAL, CREMATI REMOVAL (Specification of the company of the comp | hat I attended the ept. 11  R. G. MUT  ON, 22b. DATE THEREOF | deceased from Sept., 19 59 , and tha | t. 2 , 19 50 t death accurred at  M.D. U.  USN Be  METERY OR CREMATORY | 9, to Sep<br>2:05M,<br>ADDR<br>S. Nav<br>thesda | m the causes ESS (Street, city or to al Hesp  14, Mary  LOCATION (City, to  Montezum | s and an the awn, state) Ital  /land  wn, or county) | 9- Georginature | DATE SIGN<br>12-59<br>(State)                 |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rea, Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) . COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (Woutside corporate limits, write RURAL buriol c. LENGTH OF STAY IN 16 c. CITY OR TOWN (Moutside corporate limits, write RURAL and give nearest town) 含 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO K dir NAME OF 3. First Middle DATE Last Day Year uneral far your DECEASED OF (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE TO MARRIED 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS NEVER MARRIED 3 8. DATE OF BIRTH lost birthday) Hours WIDOWED [ DIVORCED with YES. 2 wi 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) pup puo e 2, c 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME may Pages 1, age 5 ma poges Poge 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address File Give PM3 INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line far.(a), (b), and (c), 38 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) olong with farm Hem -fronsit DUE TO .= Conditions, if ony, which pencil gove rise to immediate cause burial DUE TO (o), stoting the underlying couse last. .0 0 Examiner's Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY 00 PERFORMED? pending YES T NO [ 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) be PRIMARY S or CONTRIBUTING should ward 20c. TIME OF INJURY 20d. INJURY OCCURRED / 20a. PLACE OF INJURY (Home, form, Month, Day, Year 20f. (City or town) (County) (Stote) Ste, writing the work Chief Medicol E foctory, street, office bldg., etc.) While Not while 19.54 of work of work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry DIRECTOR: 1 Accident X deoth resulted from: Natural causes Suicide , Homicide . Undetermined couse ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER forworded O FUNERAL ASSISTANT MEDICAL EXAMINER **EXAMINER'S** Frank/J. Broschart DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) Burial (Specify) 9-23-59 Arlington Nat'l Arlington Cem ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE VS. A15ME(5) Pumphrey - Bethesda, Maryland DATE 5M 9/55

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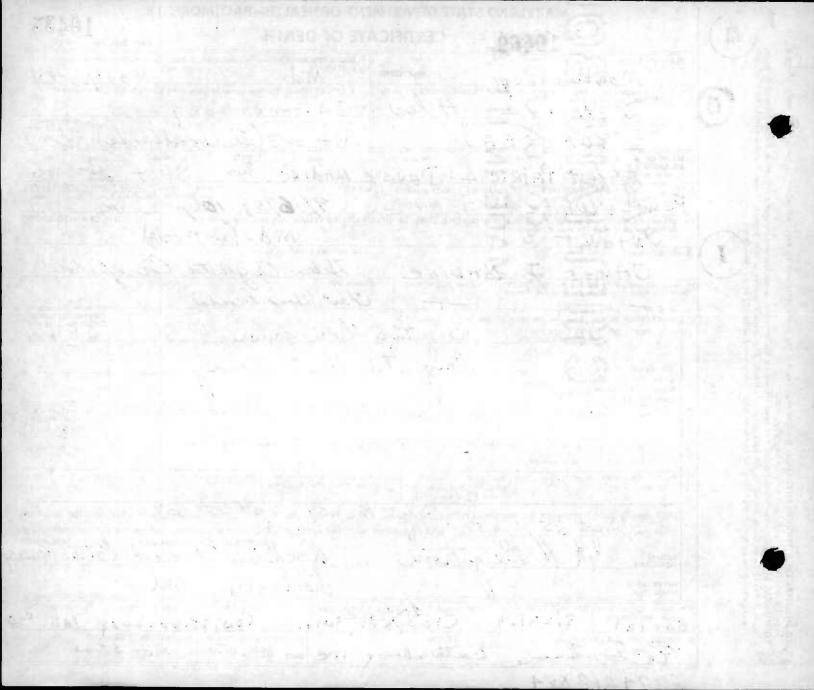
| 1035  | Q CERTIFICA  | ATE OF DEATH  |  | Reg. Dist. No.      | TOZOZ                                |
|---|--|---|--|---------------------|--------------------------------------|
| 1. PLACE OF DEATH O. COUNTY Montgomery  | MARYLAND   | 2. USUAL RESIDENCE (Who                                       | ere deceased lived. If institut<br>b. COUNTY |                     | odmission)                           |
| b. CITY OR TOWN (If outside corporate limit: RURAL and give nearest town) Takoma Park   | s, write c. LENGTH OF STAY IN 1b                         | c. CITY OR TOWN (IF or Washington                             | utside corporate limits, write f             | RURAL and give near | est town)                            |
| d. NAME OF HOSPITAL (If not in hospital, gi<br>OR INSTITUTION 7300 Baltimore Ave  | ve street oddress)                                       | d. STREET ADDRESS 3420 -16th                                  | St. N.W.Ap                                   |                     | IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF PICEASED (Type or print)   | Class h  | lost C  | 4. DATE OF DEATH SEAT MOI                    |                     | Yeor<br>1859                         |
| 77  | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED                | 8. DATE OF BIRTH 4/19/1878                                    | 9. AGE (In years lost birthday)              |                     |                                      |
| 10a. USUAL OCCUPATION (Give kind of work d<br>during most of working life, even if retired)<br>Retired Nurse                                      | one 10b. KIND OF BUSINESS OR INDU                        | Pennsy 1 v. 14. MOTHER'S MAIDEN N.                            |  | 12. CITIZEN OF      | WHAT COUNTR                          |
| David Johnston  |  | Laura Wil   |  |                     | A 2                                  |
| 1S. WAS DECEASED EVER IN U. S. ARMED FORC<br>(Yes, no. or unknown) (If yes, give wer or dates of set  | rvice)   | oseph F. Ma   | cCurdy Wash                                  | -16th S             | t.N.W                                |
| Conditions, if ony, which gove rise to immediate couse (a), stoling the under-lying couse lost.  Column Content of the content of the couse lost. | OTTONS CONTRIBUTING TO DEATH BUT                         | NOT RELATED TO THE TERMIN                                     | NAL DISEASE CONDITION GIV                    |                     | PERFORMED?                           |
| OR CONTRIBUTING CAUSE OF DEATH  | 20b. DESCRIBE HOW INJURY OCCURRE                         | D. (Enter noture of injury in P                               | ort I or Port II of item 1B.)                |                     | YES NO                               |
| 20c. TIME OF INJURY Month, Day, Yea Hour o. m. 19   | r 20d. INJURY OCCURRED 20e. PL While Not while of work 1 | ACE OF INJURY (Home, farm, ctory, street, office bldg., etc.) | 20f. (City or town)                          | (County)            | (Stote                               |
| 21. I certify that lattended the alive an   | deceased from August C                                   | occurred at 9.30 f  | M, fram the causes of                        |                     | stated abov                          |
| ACTUAL SIGNATURE COMESMY  | a thitaing   | M.D. 2701 6   | ADDRESS (Street, city of town,               | stote) 9-1          | 3-59                                 |
| 220. BURIAL, CREMATION, 22b. DATE THEREO  | itlock   22c. NAME OF CEMETERY O                         | Take we rematory  | 22d. LOCATION (City, town,                   | or county)          | (State)                              |
| REMOVAL (Specify)  Burial Sept 16  23. FUNERAL DIRECTOR'S SIGNATURE   | 1959 Ft. Linco   | 24a. REC'D  | - A - A - A                                  | STRAR'S SIGNATURE   |                                      |
| The S. H. Hines C   | lo. Washington.  | D.C. DATE   | SEP 1 8 '59                                  | Irilan & Kin        | u.l                                  |

may be retained by the haspital ar attending physician.

O FUNERAL DY OR: After this certificate has been signed by the attending physician and campletely filled in by funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filled with the registrar priar to burial, crematian, ar remaval, and in any event within 72 hours affordeath. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL Dipage 3 should be VS A15 (4) 15M 9/SS

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# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10470 CERTIFICATE OF DEATH

Reg. Dist. No. 10438

| 1. PLACE OF DEATH  | 4   |  |                | . USUAL RESIDENCE (W                                  |                         | If institution: Resider | nce befare admission)                           |
|--|---|--|----------------|---|-------------------------|-------------------------|---|
| 14   | on I dom  |  | ARYLAND        | Md  |                         | 190                     | on Toomery                                      |
| b. CITY OR TOWN ( RURAL ond give no  | If outside corporate limits                                 | , write c. LENGTH OF S                               | STAY IN 16     | c. CITY OR TOWN IIf                                   | autside corporate lim   | its, write RURAL and    | give newrest town)                              |
| Silver   |   | 4 答 //   | rs             | 56 S1/V   | er So                   | rind                    | 10. 10  |
| d. NAME OF HOSPIT  | TAL (If not in haspital) giv                                | re street oddress)                                   |                | d. STREET ADDRESS                                     | 1.                      | 6                       | e. IS RESIDENCE                                 |
| or institution   | in Road   |  |                | 303 /   | larvin                  | Roal                    | YES NO  |
| 3. NAME OF<br>DECEASED   | First   | Mi   | iddle          | Lost  | 4. DATE                 | Month                   | Day Year  |
| (Type ar print)  | Virgini   | a L.   | ^              | Partell   | OF<br>DEATH             | Sept                    | 26 1959   |
| S. SEX   | 6. COLOR OF RACE  | 7. MARRIED NEVER MA                                  | ARRIED 8. I    | DATE OF BIRTH   | 9. AGE                  | 1                       | TYEAR IF UNDER 24 HRS.                          |
| Female   | 120   | WIDOWED DIVO   | RCED   J       | an. 6, 1867   |                         | Months yrs.             | Days Hours Min.                                 |
| Oo. USUAL OCCUPATION   | ON (Give kind af wark do                                    | ne 10b. KIND OF BUSINE                               | SS OR INDUSTR  | Y 11. BIRTHPLACE (State                               |                         |                         | IZEN OF WHAT COUNTRY?                           |
| during most af wor   | king life, even if retired)                                 |  |                |   |                         | 54 17 1 33              | II C A  |
| 3. FATHER'S NAME   | r, retired  | Own Home   | 1              | Quebec,   |                         |                         | U. S. A.  |
| S. PATHER'S NAME   |   |  |                |   | NAME                    |                         |   |
| Unknown  |   | ille   |                | Unknown   |                         |                         | 40  |
|  | ER IN U. S. ARMED FORC<br>(If yes, give wor or dates of ser | ES? 16. SOCIAL SECURITY                              |                | RMANT   |                         | Address                 | (Spring, Md                                     |
| No   |   | None   | Mrs.           | Ralph S. S  | adler, 30               | Marvin R                | d.,Silver                                       |
| 422.1<br>Canditions, if a<br>gave rise to i<br>couse (a), stating<br>lying couse last. | the under-  | Arterio-sc   | lerotie        | cardio-va   | soulard                 | disease                 |   |
| 3  |   | itions <u>contributing</u> to                        | DEATH BUT NO   | OT RELATED TO THE TERM                                | INAL DISEASE COND       | ITION GIVEN IN PAI      | RT 1(a) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| 20a. ACCIDENT WAY OR CONTRIBUTING (IF EITHER, NOTIFY                                   | AS UNDERLYING CONTROL OF CAUSE OF DEATH                     | 06. DESCRIBE HOW INJUI                               | RY OCCURRED. ( | Enter nature af injury in                             | Port I ar Port II of it | em 18.)                 |   |
| 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.  | RY Month, Day, Year<br>19                                   | 20d. INJURY OCCURRED While Not while of wark of wark | foctor         | OF INJURY (Hame, farm<br>y, street, office bldg., etc |                         | n) (                    | (County) (State)                                |
| 21. I certify th   | nat I attended the  | deceased from Va                                     | nuary :        | 3 . 1957 . ta 50                                      | ept. 26                 | . 19.59that I le        | ast saw the deceased                            |
| alive on Se  | pt 26   |  |                | 00  | .(                      |                         | e date stated abave                             |
| Lacrus /   | 11  | 2 11   |                |   | ADDRESS (Street, cit    | y or town, stote)       | DATE SIGNED                                     |
| SIGNATURE  | aymond a  | radstra  | M.[            | 3450  | MINERSIL                | y DIVA,                 | West 9/26/                                      |
| PHYSICIAN'S<br>NAME (Type)   | aymond)   | Bradshau   | W              | Silver  | Spring,                 | Md.                     |   |
| 2a. B. CREMATIC<br>REMOVAL (Specify)   | 0M, 22b. D. D. P. F. F. G. P.                               | 22c. NAME OF   | CEMETERY OR C  | REMATORY  | 22d. LOCATION (C        | ity, town, or county)   | (Stote)   |
| Oct. 1,195   | 9 Burial  | St. Jo   | seph's (       | Cemetery  | Monroe,                 | Michigan                |   |
| Raymon   | S SIGNATURE PUMPHREY  | INC., SILVER   | SPRING,        |   | P 2 9 59                | 24b. REGISTRAR'S S      | GNATURE /                                       |

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# **CERTIFICATE OF DEATH**

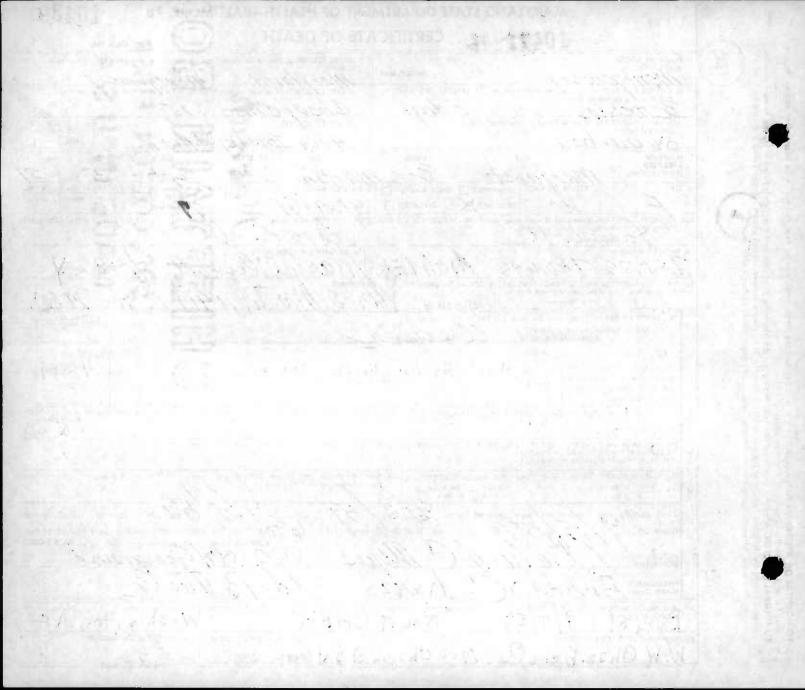
Rea. Dist. No.

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|---|---|--|---------------------------------|--|---|--|---|
| ) | 1. PLACE OF DEATH a. COUNTY                               | merv   | MARYLAND                        | 2. USUAL RESIDENCE<br>o. STATE                     | (Where deceased live                    | d. If institution: Reside<br>b. COUNTY |   |
|   | b. CITY OR TOWN (I<br>RURAL and give no                   | f outside corporate limits, write<br>corest town)                            | c. LENGTH OF STAY IN 16         | c. CITY OF TOWN                                    | (If outside corporate I                 | limits, write PURAL ond                |   |
| - | d. NAME OF HOSPIT<br>OR INSTITUTION                       | AL (If not in hospital, give street  - bau                                   | oddress)                        | d. STREET ADJORES                                  | Badba                                   | Int And                                | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                 |
|   | 3. NAME OF<br>DECEASED<br>(Type or print)                 | First Malana et  | Middle                          | Lost   | 4. DATE<br>OF<br>DEATH                  | Month                                  | Day Yeor  |
|   | S. SEX  | 6. COLOR O'R RACE 7. MARE  | RIED NEVER MARRIED DIVORCED     | 8. DATE OF BIRTH                                   | 9. A                                    | GE (In years ast birthdoy) Months      | R 1 YEAR IF UNDER 24 HRS.  Doys Hours Min.              |
|   | during record of work                                     | DN (Give kind of work done 10b. king life, even if refired)                  | (—)                             | JSTRY 11. BIRTHPLACE (S                            | tote or foreign country                 |  | TIZEN OF WHAT COUNTRY?                                  |
|   | 13. FATHER'S NAME   | Thomas   | MohLER                          | 14. MOTHER'S MAID                                  | EN NAME PLIA                            | let He                                 | PRVLX   |
| Ī |   | R IN U. S. ARMED FORCES? 16.   | SOCIAL SECURITY NO.             | INFORMANT MA                                       | The 1                                   | Address                                | t. 2100.  |
|   |   | TH [Enter only one couse per li TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO | ne for (o), (b), and (c).]      | kvitis, se   | 10100                                   |  | INTERVAL BETWEEN ONSET AND DEATH                        |
|   | gove rise to i<br>couse (o), stating<br>lying couse last. | m mediote  |                                 |  |   | NDITION GIVEN IN PA                    | RT 1(o) 19. WAS AUTOPSY PERFORMED?                      |
| 4 | 20a. ACCIDENT WA  | S UNDERLYING 20b. DES  | CRIBE HOW INJURY OCCURR         | ED. (Enter noture of injury                        | y in Port I or Port II o                | f item 18.)                            | YES MO  |
|   | 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.                 | Y Month, Doy, Year 20d. II<br>While<br>of wor                                | _ Not while _                   | LACE OF INJURY (Home, octory, street, office bldg. | farm, 20f. (City or to                  | own)                                   | (County) (State)  |
|   | 21. I certify the alive an                                | of 1 oriended the deceas   | ed fram. 9/3<br>, and that degr | h accurred at 6                                    | * |  | ast saw the deceased ne date stated abave.  DATE SIGNED |
| 1 | PHYSICIAN'S<br>NAME (Type)                                | CHARD(   | 7 Mysta                         | s R  | d. Bet                                  | lus da                                 |   |
|   | 220 BURIAL, CREMATIO                                      | 9/9/59   | 22c. NAME OF CEMETERY           | Creek  |   | 44 -1011.14                            | gtm, AC   |
|   | 23. FUNERAL DIRECTOR                                      | ambers C   | 1400 Chapi                      | 3 ST N. V DATE                                     | P 9 '59                                 | 24b. REGISTRAR'S'S                     |   |

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| 1.            | Montgome  | ry   |                               | MARY   | LAND            | 2. USUAL RESIDI   |                          | ere deceased           | b. COUN<br>Montg             | ITY        |                      | are admiss              | ian)                 |
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|               | d. NAME OF HOSPIT<br>OR INSTITUTION   | AL (If not in hospital, lorick Ave.  | give street                   | address)                                       |                 | d. STREET AD  / 114 F:  |                          | iok A                  | ve.,                         |            |                      |                         | FARM?                |
|               | NAME OF<br>DECEASED<br>(Type or print)  |  | rst<br>RMEN                   | Middle   |                 | MASON   |                          | 4. DATE<br>OF<br>DEATH |                              | Sept.      |                      | -/                      | Yeor<br>19 <b>59</b> |
| 5.            | Female  | 6. COLOR OR RACE<br>Colored  | 7. MARR                       | NEVER MARRIE                                   |                 | 8. DATE OF BIRTH Sept. 15   | , 190                    | )4                     | 9. AGE (In year last birthda | y) Hont    | DER 1 YEA            | R IF UNDI<br>Hours      | ER 24 HRS.<br>Min.   |
| 100           | USUAL OCCUPATION during most of work  | king life, even if retired   | dane 10b.                     | KIND OF BUSINESS O                             | R INDUS         |   | CE (State                | _                      | ountry)                      | 12.        | CITIZEN C            | S. A.                   |                      |
| 13.           | FATHER'S NAME   | Charles  | A. H:                         | 111  | 4               | 14. MOTHER'S A  |                          | Smith                  |                              |            |                      |                         |                      |
|               | WAS DECEASED EVE  | R IN U. S. ARMED FOI<br>(If yes, give war or dates of                                  | RCES? 16.                     | SOCIAL SECURITY NO                             |                 | MOS A. M  | ason                     | It                     | em 2                         | ddress     | -                    | 1                       |                      |
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| CERTIFICATION |   |  |                               | THENE  |                 |   |                          |                        |                              |            | PART 1(a)            | 19. WAS<br>PERFC<br>YES | RMED?                |
|               | OR CONTRIBUTING   | AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  | 20b. DES                      | CRIBE HOW INJURY O                             |                 |   |                          |                        | Ill of item 18.)             |            |                      |                         |                      |
| MEDICAL       | 20c. TIME OF INJUR<br>Hour a.m.<br>p. m.                                      | Y Month, Doy, Ye   | or 20d. II<br>While<br>of wor | NJURY OCCURRED  No while  at wark              | 20e. PLA<br>fac | CE OF INJURY (H<br>tory, street, affice   | ome, farm<br>bldg., etc. | 20f. (City             | or town)                     |            | (County              | )                       | (Stote)              |
|               |   | at I attended the  | deceas<br>, 19                |  |                 | accurred at,  |                          |                        |                              | and an     | l last sa<br>the dat | e stated                |                      |
| 220           | BURIAL, CREMATIC<br>REMOVAL (Specify)   | 9/18/59  |                               | 22c. NAME OF CEME<br>Arlingt                   | tery o          | crematory<br>ational,   |                          | 22d. LOCA              | ION (City, tow               | n, or cour | nty)                 | (Stat                   | e)                   |
| 23.           | FUNERAL DIRECTOR  | 'S SIGNATURE   | Ao. I                         | ADDRESS<br>Rockville.                          | Md.             |   |                          | BY REGIST              |                              | GISTRAR'   | S SIGNATI            | JRE                     |                      |

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(State)

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VS A15 (4) 15M 10/57

23. FUNERAL DIRECTOR'S SIGNATURE

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# MADVIAND STATE DEPARTMENT OF HEALTH PALTIMODE 19

|   | 10/6  |                             | CERTIFIC                   |   | -BALTIMORE, 10                           | 1044   |
|---|---|-----------------------------|----------------------------|---|--|--|
|   | 1047  | 3                           | CERTIFICA                  | ATE OF DEATH  |  | Reg. Dist. No.                                   |
| 1. PLACE OF DEATH a. COUNTY Montgome:     | cy  | 36                          | MARYLAND                   | 2. USUAL RESIDENCE (Where o. STATE Pennsylvania                 | deceased lived. If institution b. COUNTY | Residence befare admission)                      |
| b. CITY OR TOWN (                         | If autside carporate lim                            | its, write                  | c. LENGTH OF STAY IN 1b    |   | de carporate limits, write RUR           | AL and give nearest tawn)                        |
| Bethesda                                  | earest rawing                                       |                             | 17 days                    | Summerhill  | 75                                       | X = 3  |
| d. NAME OF HOSPI<br>OR INSTITUTION        | TAL (If not in haspital, g                          | give street                 | address)                   | d. STREET ADDRESS   |  | e. IS RESIDENCE                                  |
| The Clin                                  | ical Center   | . Bet                       | hesda lh. Md.              | Box 205   |  | ON A FARM? YES NO TO                             |
| 3. NAME OF                                | Fi  |                             | Middle                     |   | DATE Month                               | Day Year   |
| (Type or print)                           | Thoma   | S                           | Jerome                     | McCall  | OF DEATH Septem                          |  |
| 5. SEX                                    | 6. COLOR OR RACE                                    | ,                           | IED NEVER MARRIED          | B. DATE OF BIRTH  | 9. AGE (In years IF                      | UNDER I YEAR IF UNDER 24 HRS                     |
| Male                                      | White   | WIDOWE                      | DIVORCED                   | August 25. 19   |  | Manths Days Haurs Min.                           |
| 10a. USUAL OCCUPATION                     | ON (Give kind of work<br>king life, even if retired | dane 10b.                   | KIND OF BUSINESS OR INDU   | STRY 11. BIRTHPLACE (State or f                                 |  | 12. CITIZEN OF WHAT COUNTE                       |
| Student                                   | king me, even it terred                             | -                           | None                       | Pennsyl   | vania                                    | U.S.A.   |
| 13. FATHER'S NAME                         |   |                             |                            | 14. MOTHER'S MAIDEN NAM   |  |  |
| Thomas Me                                 | Call  |                             |                            | Esther Noon   |  |  |
| 15. WAS DECEASED EVI                      | R IN U. S. ARMED FOR                                |                             | SOCIAL SECURITY NO. 17.    |   | cal RecordAddress                        |  |
| No  | In yes, give war or dates or s                      |                             | 210-28-7674 T              | he Clinical Cen   |  |  |
| 18. CAUSE OF DE                           | ATH [Enter anly one co                              | use per lir                 | ne far (a), (b), and (c).] |   |  | INTERVAL BETWEEN                                 |
| PART I. DE                                | ATH WAS CAUSED BY: IMMEDIATE CAUSE (c               | Pe                          | ritonitis                  |   |  | ONSET AND DEATH                                  |
| 199.2                                     | DUE TO  |                             |                            |   |  |  |
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| gave rise to i                            | mmediate (  | -                           |                            |   |  |  |
| lying cause last.                         | le olider   | )                           |                            |   |  |  |
| PART II. OT                               | HER SIGNIFICANT CON                                 | DITIONS C                   | ONTRIBUTING TO DEATH BUT   | NOT RELATED TO THE TERMINAL                                     | DISEASE CONDITION GIVEN                  | I IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
|   | AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)     | 20b. DESC                   | CRIBE HOW INJURY OCCURRE   | D. (Enter nature of injury in Part                              | 1 or Part 11 of item 18.)                |  |
| 20c. TIME OF INJUI<br>Hour a. m.<br>p. m. | Y Manth, Day. Ye                                    | 20d. IN<br>While<br>at wark | _ Nat while fa             | ACE OF INJURY (Home, farm, 2 clary, street, affice bldg., etc.) |  | (County) (State                                  |
| 21. I certify th                          | nat I attended the                                  | decease                     | ed from August 2           | 5 1959 to Sept  | ember 11 <sub>19</sub> 59                | that I last saw the deceas                       |
| alive an Sep                              | tember 11   | , 19 5                      |                            | accurred at 3:40 A M  |  | d on the date stated abar                        |
| ACTUAL<br>SIGNATURE                       | marlin  | 5                           | May and                    | The Clinical  |  | 9/11/59  |
|   |   |                             |                            |   | titutes of He                            | alth   |
| PHYSICIAN'S<br>NAME (Type)                | CHARLES E.  | MENG                        | EL. M.D.                   | Bethesda 14.  |  |  |

TO HOSPITAL OR VS A15 (4) 15M 10/S7

220. BURIAL, CREMATION, PEMOVAL (Specify)

22b. DATE THEREOF

SIGNATURE

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) Cambria Co.

(State) Pennsylvania

ADDRESS Bethesda, Md.

24a. REC'D BY REGISTRAR DATE SEP 1 5 '59

24b. REGISTRAR'S SIGNATURE arthur S. Kraus

| S PART ST SAGMITIZA-10   |               | STATE DEPART    |  |  |
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| 34475  |                              |                                       | Reg.  | Dist. No.                                   |
|--|------------------------------|---------------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY  Montgomery  | MARYLAND                     | 2. USUAL RESIDENCE (Who o. STATE Ohio | nere deceased lived. If institution: Resid<br>b. COUNTY | tence befare admission)                     |
| b. CITY OR TOWN (If autside carporate limits, write<br>RURAL and give nearest town)  | c. LENGTH OF STAY IN 16      | c. CITY OR TOWN (If o                 | iutside carporate limits, write RURAL an                | nd give nearest town)                       |
| Bethesda   | 105 days                     | Fairborn                              | 72 X - 3  | 3   |
| d. NAME OF HOSPITAL (If not in hospital, give stree<br>OR INSTITUTION  | t address)                   | d. STREET ADDRESS                     |   | e. IS RESIDENCE<br>ON A FARM?               |
| The Clinical Center, Be  | thesda ll. Md.               | 64 North Wr                           | right Avenue  | YES NO 🌃                                    |
| 3. NAME OF First   | Middle                       | Last                                  | 4. DATE Month   | Day Year                                    |
| (Type or print) Grover   | William                      | McCoy                                 | DEATH September   | 30 1959                                     |
| 5. SEX 6. COLOR OR RACE 7. MAI   | RRIED NEVER MARRIED          | B. DATE OF BIRTH                      |   | DER ! YEAR IF UNDER 24 HRS                  |
| Male White WIDOV   | VED DIVORCED                 | September 24.                         | 1892 67 yrs. Manth                                      | s Days Haurs Min.                           |
| 10a. USUAL OCCUPATION (Give kind of work dane 10t  | . KIND OF BUSINESS OR INDU   |                                       |   | CITIZEN OF WHAT COUNTR                      |
| Accounting Clerk   | Government (Re               | tired) Ohio                           |   | U. S. A.                                    |
| 13. FATHER'S NAME  | A TOTAL LAND                 | 14. MOTHER'S MAIDEN N                 |   |   |
| Jananh MaCore  |                              | Evangeline                            | West.   |   |
|  | S. SOCIAL SECURITY NO. 17. I | NFORMANT The Med                      |   |   |
| (Yes, no, or unknown) (If yes, give war or dates of service)   |                              |                                       | enter. Bethesda 14                                      | . Maryland                                  |
| 18. CAUSE OF DEATH [Enter only one cause per   |                              | de cituitear of                       | mer, be mesua 14  | INTERVAL BETWEEN                            |
| DART I DEATH WAS CAUSED BY   |                              |                                       |   | ONSET AND DEATH                             |
| IMMEDIATE CAUSE (a)  | rdie-resp. Arre              | EU                                    |   | 1 hour                                      |
| 1992 DUE TO  |                              | Market No.                            |   |   |
| Conditions, if any, which (b) Ma   | lignant metasta              | tie carcinoid                         |   | 6 years                                     |
| cause (a), stating the under-  |                              |                                       |   |   |
| lying cause last. (c)  |                              |                                       |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  OR CO | CONTRIBUTING TO DEATH BUT    | NOT RELATED TO THE TERMI              | NAL DISEASE CONDITION GIVEN IN P.                       | PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
|  | SCRIBE HOW INJURY OCCURRE    | D. (Enter nature of injury in f       | <sup>2</sup> art I or Port II of item 18.)              |   |
| 2  | l for                        | ACE OF INJURY (Home, form             | , 20f. (City or town)                                   | (County) (State                             |
| Hour a.m. 19 While the way of the | e Nat while                  | ctary, street, affice bldg., etc.     |   |   |
| 21. I certify that I attended the deced  |                              | 10 50 . Set                           | ptember 30 1959 that                                    | 11  |
|  |                              |                                       |   |   |
| alive an September 30 , 19   | 37, and that death           |                                       | P.M. fram the causes and an                             | the date stated aba<br>DATE SIGN            |
| ACTUAL & CA O. O.  | M                            |                                       |   | DATE SIGN                                   |
| SIGNATURE CALLOS   | Vicen got                    |                                       | ical Center   | 10/1/5                                      |
| PHYSICIAN'S NAME (Type) Charles E. Menge   | el. M.D.                     |                                       | Institutes of Hea                                       | 11.cu                                       |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF BURIAL Specify Burial Transit 10/1/5   | 22c. NAME OF CEMETERY O      |                                       | 22d. LOCATION (City, town, or county Dayton, Ohio       | y) (State)                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE   | ADDRESS                      | 240. REC'                             | D BY REGISTRAR 24b. REGISTRAR'S                         | SIGNATURE                                   |
| Robert A. Pumphrey   | Bethesda, Ma                 | ryland DATE 0                         | CT 5 2 '59 Cirim  | & Thomas                                    |

DATE

After this certificate has been signed by the attending physician and campletely filled in by the Annera hed far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be page 3 shauld be made for use as the burial-transit permit. Then please remave carban papers. the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. R: After this certificate has been signed by ached far use as the burial-transit permit. TO FUNERAL DIRE
page 3 shauld be

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft

TO HOSPITAL OR

VS A15 (4) 15M 10/57

death: Page

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTHMORE, IS CERTHEICATE OF DEATH

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# TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs fer death. Page 25 or may be retained by the hospital ar attending physician. TO FUNERAL DESCRIPTION: After this certificate has been signed by the attending physician and completely filled in by the funeral directions and shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filled the registrar prior to burial, crematian, ar remaval, and in any event within 72 haurs after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH** 

10444

| 10476 CERTIFIC  | CATE OF DEATH Reg. Dist. No.   |
|---|--|
| 1. PLACE OF DEATH 0. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY |
| martagenery MARYLAN   | b. COUNTY  |
| b. CITY OR TOWN If autside carparate limits, write RURAL and give hearest town)   | b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn)                       |
| Betherda 18 Krs   | 1 Washington 47x3  |
| d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION  | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES NO   |
| 3. NAME OF First Middle   |  |
| 3. NAME OF DECEASED (Type or print) M John  | Last 4. DATE Month Day Year OF DEATH LEAT. 29 1959   |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED  | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.                                       |
| gusli white WIDOWED DIVORCED  | last birthday) Months Days Haurs Min   |
| 10a. USUAL OCCUPATION (Give kind of wark done during mast of warking life, even if retired)   | IDUSTRY 11. BIRTH ACE (State or fareign country)   |
| Day. Thenting Office Ilanner  | Mary U.S.A.  |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.  | INFORMANT Address  |
| (Yes, no. or unknown) (If yes, give wor or dates of service)  | (wite Same, or about)  |
| 18. CAUSE OF DEATH [Enter only ope cause per line far (a), (b), and (c).]   | INTERVAL BETWEEN   |
| PART I. DEATH WAS CAUSED BY:  | ONSET AND DEATH  |
| 333 IMMEDIATE CAUSE (o) CARCOLI SA  | mradiunial inessine 20 mous  |
| Conditions, if any, which)  | haret (Left frontal Cafe) 6 web  |
| gave rise to immediate  |  |
| lying cause last. (c) with intra  | ventrisular hemarchage 20 hours  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH  20a. ACCIDENT WAS UNDERLYING  CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER) | BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO  |
|   | RRED. (Enter nature of injury in Part I ar Part II of item 18.)  |
|   | PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote)  |
| Haur a. m.  P. m.  19 While Not while of work at wark   | factory, street, affice bldg., etc.)   |
| 21. I certify that I attended the deceased fram. Sept.  | Perchel 1957, to Dept 29, 1959 that I last saw the deceased  |
| alive an 221 28 , 19.59 , and that de   | ath accurred at AM, from the causes and an the date stated above.  |
| 1 OSA 1/2   | ADDRESS (Street, city or tawn, state) DATE SIGNED  |
| SIGNATURE MICHOLDA HEALY  | M.D. Washington Clinis Which DC 9/24/59  |
| PHYSICIAN'S NAME (Type) Michel M. Healy   | Washington Clinin, Wash. D. C.   |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETER  |  |
| 201202  | eaven Silver Spring, Maryland  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  | Openie 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE  |
| Robert A. Pumphrey Bethesda, M  | Styland DATEDCT 2'59 archur & thomas   |

# The second secon A CONTRACTOR OF THE SECOND PROPERTY OF THE SE and case to the sevent of the second to see the cort. the second of th

| 24 h  | Page   | abi  | od e  | ١ |
|---|--|--|---|---|
| within  | Give   | M3. PM   | it. All   | - |
| TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 h | he certificate, writing the ward "pending" in pencil in Item 18. Giv | orded to hief Medical Examiner's Office along with farm PM3. | IERAL DISCOR: Page 3 should be used as a burial-transit permit. A |   |
| TO DE   | cute   | forw   | TO FUI  |   |
| VS.   | . A<br>5M  | 15/  | ME(<br>55   | 5 |
|   |  |  |   |   |

|  | 10477                     | EDICAL           | EXAMIN   | ER'S     | CERTIFICAT                    | TE OF           | DEATH               | Reg. Dist.      | 1(4)               | 35     |
|--|---------------------------|------------------|--|----------|-------------------------------|-----------------|---------------------|-----------------|--------------------|--------|
| 1. PLACE OF DEATH                              | 70711                     |                  |  |          | 2. USUAL RESIDENCE (V         | Vhere decease   | d lived. If institu | tion: Residence | before admission   | )      |
| o. COUNTY                                      | amory                     |                  | MARY   | LAND     | o. STATE                      |                 | b. COUNT            |                 | V                  | 1      |
| b. CITY OR TOWN (                              | one vy                    | e RURAL          | c. LENGTH OF STAY  | 100      | c. CITY OR TOWN (IF           | outside corpo   | prote limits, write | RURAL and giv   | e nearest town)    |        |
| and give nearest town                          | n)<br>esclo               |                  | 10 10  |          | 11/1/20 h.                    | : 1             |                     | 1144            | 2                  |        |
|  | TAL OR INSTITUTION (      | If not in hospit | al give street address   | 4.2      | d. STREET ADDRESS             | ngTo            | 089                 | 4-11            | e. IS RESIDI       | ENCE   |
| Subus  | hon                       |                  | -, 8   |          | 1351 G                        | .vor            | 1157                |                 | YES N              | RM?    |
| . NAME OF                                      | Fir                       |                  | Middle   |          | Lost                          | 4. DATE         | 901.                |                 |                    | 0 12   |
| (Type or print)                                | 111.11:00                 | t a a            | elbolm<br>دخ   | m        | CK: 181                       | OF<br>DEATH     | Montl               |                 | ay Year            | ~      |
| SEX  | 6. COLOR OR RACE          | 7. MARRIED       | NEVER MARRIED  | 1//      | DATE OF BIRTH                 |                 | P. AGE (In years    | IF UNDER TYE    | AR IF UNDER 2      |        |
| in   | G. COLOR OR RACE          | WIDOWED I        |  | -        | DAIE OF BIKIN                 |                 | last birthday)      | Months Day      |                    |        |
| - UCHAL OCCUBATI                               | Ohl (Cina blad of made    |                  |  |          | VIII DIRTING ACC IC. A        |                 | 49 ; yrs.           | 10 0000         |                    |        |
| during most of working                         | ng life, even if retired) | done IUD. KIN    | ID OF BUSINESS OR I  | MDOZIK   | Y 11. BIRTHPLACE (Stole       | or foreign co   | untry)              | 12. CITIZEN     | OF WHAT COL        | INTRY  |
| LUDOY  | er                        | Cor              | 757 ructio   | 27       | Georgi                        |                 |                     | 1 6             | la,                |        |
| B. FATHER'S NAME                               |                           |                  |  |          | 14. MOTHER'S MAJDEN N         | NAME            |                     |                 |                    |        |
| U  | nknow                     | 7                |  |          | 61                            | Inti            | 704- K              | 7               |                    |        |
| 5. WAS DECEASED EV                             | ER IN U. S. ARMED FO      | RCES? 16. SC     | CIAL SECURITY NO.  | 17. IN   | FORMANT                       | _               | Address             | 1351            | Sirand             | 57.    |
| No   |                           | 2                |  | 19/1     | ce Miles                      | (Fosie          | rmother             | wash            | . D.C.             |        |
| 18. CAUSE OF DEA                               | TH [Enter only one cau    | use per line for | (o), (b), and (c).]  | 1        |                               |                 |                     | #               | NTERVAL BETWEEN    |        |
| PART I. DEA                                    | TH WAS CAUSED BY:         | U                | reme   | à        |                               |                 |                     |                 | 20                 | 21-1-6 |
| 1910.3   | DUE TO                    | -                | 0  | 0        | 0                             | 4.124           |                     |                 | d .                | 0      |
| Conditions, if a                               | iny, which) (b)           | Ke               | mal +  | ace      | Luso                          |                 |                     |                 | 4 Day              | 10     |
| gove rise to imme                              | diate couse               | 01               | 1 0  |          | 1                             |                 |                     |                 | 100                | 1      |
| (o), stating the couse lost.                   | underlying (c)            | Ch               | outh J.  | ne       | ures                          |                 |                     |                 | 10 Way             | 1      |
| PART II. OTI                                   | HER SIGNIFICANT CON       | DITIONS CON      | TRIBUTING TO DEATH   | BUT NO   | OT RELATED TO THE TERMI       | NAL DISEASE     | CONDITION GIV       | EN IN PART 1(a  | 19. WAS AUTO       | OPSY   |
| PART II. OTI                                   |                           |                  |  | - 0      |                               |                 |                     |                 | PERFORME<br>YES NO | 0?     |
| 20g. EXTERNAL CA                               | USE WAS 20                | b. DESCRIBE H    | OW INJURY OCCUR  | RED. (En | ter noture of injury in Port  | t Lor Port II o | of item 18 )        |                 | 100 (2)            |        |
| 20g. EXTERNAL CAPRIMARY OF CO. CAUSE OF DEATH. | NTRIBUTING 10             | An               | 1  | 1 1      |                               |                 |                     | 0               |                    |        |
|  | RY Month, Day, Yea        | or 20d INI       | HIRY OCCURRED 20   |          | E OF INJURY (Home, form       |                 | or town)            | (County)        | 15                 | tote)  |
| Hour orm.                                      | eA.                       | While            | Not while  | fector   | y, street, office bldg., etc. | 20(0.1)         |                     | (Coomy)         | 13                 | olej   |
|  |                           | of work          |  |          | ridey.                        | 134             | Minde               | more            | by M               | 4      |
| 21. I certify the                              | nat I took charge         | of the rea       | mains described  | abov     | e, held an Autops             | y X, Ins        | spection [],        | Inquiry [       | , and find         | the    |
| death resulted                                 | from: Natural             | causes,          | Accident ,   | Suici    | ide 🔲, Homicide               | , Un            | determined o        | ause .          |                    |        |
|  | 7                         | 2                | ,  |          |                               |                 |                     |                 | 0479 61614         | ED     |
| SIGNATURE 7                                    | 2042 4-1                  | mon              | track-   |          | M.D. CHIEF MEDICAL EX         | AMINER [        |                     |                 | DATE SIGNI         | .0     |
| PV A AMARIENIA                                 | - 1 .                     | - D              |  |          | ASSISTANT MEDICA              | AL EXAMINER     |                     |                 |                    |        |
| EXAMINER'S<br>NAME (Type)                      | HANK                      | J- 131           | roschaut   | -        | DEPUTY MEDICAL                | EXAMINER D      | k 9.                | - 2             | 59                 |        |
| O BURIAL, CREMATIC                             |                           | OF   22          | c. NAME OF CEMETE  | RY OR C  | REMATORY                      | 22d. VOÇATI     | ON (Ci)() town,     | or county)      | (Stote)            |        |
| REMOVAL (Specify)                              | 19-5-                     | 59               | Lingol   | w.       | Mensonol                      | . Xui           | itland              | Ord.            | mn                 |        |
| 3. FUNERAL DIRECTOR                            | 'S'SIGNATURE              |                  | ADDRESS  | 1        | 240. REC'I                    | BY REGISTR      | AR 24b. REGIS       | TRAR'S SIGNA    | LURE               | •      |
| MARIO  | (Drog)                    | , 6              | 21+0   | 11.11    | 110 NU DATE S                 | SEP 4           | 08                  | title failth    | CLANIES .          |        |
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|            |       | MEDICAL EXAMINER   |  |
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|                          | THE RESERVE |  |
|                          |             | CONTRACTOR OF THE PROPERTY OF  |
|                          |             |  |

10447

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| Montgome   | сy   | MARYLAND                         | 2. USUAL RESIDENCE (WHO O. STATE District | ere deceased lived.  of Column | If institution: F     | Residence before | admission)                |
|--|--|----------------------------------|---|--------------------------------|-----------------------|------------------|---------------------------|
| b. CITY OR TOWN (I   | f outside corporate limits, write  | c. LENGTH OF STAY IN 16          | c. CITY OR TOWN (If o                     |                                | its write RURA        | L and give negre | st town)                  |
| RURAL ond give ne  | earest town)   |                                  |   |                                | , , ~                 | . / 2            |                           |
| Bethesda   | (Rural) AL (If not in hospital, give street  |                                  | d. STREET ADDRESS                         | 4                              | 4-1                   | X-3              | IS DESIDENTED             |
| OR INSTITUTION   |  |                                  |   |                                | -                     | e.               | ON A FARM?                |
| U.S. Nava.   | l Hospital, E  | Bethesda, Md                     | 627 Forres                                | ster St.                       | SE                    | <u> </u>         | YES NO X                  |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                | Peter  | Madison                          | MINCEY                                    | 4. DATE<br>OF<br>DEATH         | Month<br>Septemb      | per 6            | Year<br>1959              |
| S. SEX   | 6. COLOR OR RACE 7. MAR  | RIED NEVER MARRIED               | B. DATE OF BIRTH                          | 9. AGE                         |                       | INDER 1 YEAR IF  |                           |
| Male   | White widow  | ED DIVORCED                      | 14 May 1956                               | 5 3                            | birthdoy) Mo          | onths Doys H     | dours Min.                |
| 10a. USUAL OCCUPATIO   | N (Give kind of work done 10b.   | KIND OF BUSINESS OR INDU         | STRY 11. BIRTHPLACE (Stote                | or foreign country)            | 1                     | 2. CITIZEN OF W  | HAT COUNTRY?              |
| child  | ing life, even if retired)   | hild                             | Hawaii                                    |                                |                       | U.S.             |                           |
| 13. FATHER'S NAME  |  |                                  | 14. MOTHER'S MAIDEN N                     | IAME                           | 3                     |                  |                           |
| Andrew V:  | an MINCEY  |                                  | Lavon MCD                                 | OHGAT.T.                       |                       |                  |                           |
| 15. WAS DECEASED EVEL  |  | SOCIAL SECURITY NO.              | INFORMANT                                 | OUADD                          | Address               |                  |                           |
| (Yes, no, or unknown)  | (If yes, give war or dates of service)   | 1                                | Father) And:                              | rew Van                        | MINCE                 | Same             | as #2                     |
|  | THE Contraction of the Contracti |                                  | radici / ilia.                            |                                |                       |                  | AL BETWEEN                |
|  | TH [Enter only one couse per li  | the lot (o), ond (c).            |   | 1                              | 4.1                   | ONSET            | AND DEATH                 |
| 01100  | IMMEDIATE CAUSE (o)  | ment m                           | unen gr TIS                               | and                            | Nacro                 | mail             | 1 days                    |
| 340.3  | DUE TO   |                                  |   | pre                            | umon.                 | 9                |                           |
| Conditions, if or  |  |                                  |   |                                |                       |                  |                           |
| gove rise to in<br>couse (o), stoting                                    |  |                                  |   |                                |                       |                  |                           |
| lying couse lost.  | (c)  |                                  |   |                                |                       |                  |                           |
| PART II. OTH   | IER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BU         | NOT RELATED TO THE TERMI                  | NAL DISEASE CONE               | ITJON GIVEN           | N PART 1(o) 19.  | WAS AUTOPSY<br>PERFORMED? |
| 3 Hydro  | aphalus w  | Ith ventri                       | ulo- jugu                                 | lay s                          | hunt                  |                  | ES NO                     |
| PART II. OTH Hydro  200, ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY | S UNDERLYING 20b. DES CAUSE OF DEATH MEDICAL EXAMINER)   | CRIBE HOW INJURY OCCURRI         | ED. (Enter notute of injury in I          | Port I or Port II of it        | em 18.)               |                  |                           |
| 3 20c. TIME OF INJUR   | Y Month, Day, Year 20d. I  |                                  | ACE OF INJURY (Home, form                 |                                | n)                    | (County)         | (Stote)                   |
| 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.                                | 19 While of wor  | INDI WILLIE                      | octory, street, office bldg., etc.        | )                              |                       |                  |                           |
|  |  | 21 110                           | 10.59 + 6                                 | Sept.                          | 59.                   |                  |                           |
|  | at I attended the decease Sept. 195  | CO HOIL STATE                    | occurred at 1:35.                         |                                | ., 19 <u>-4-7</u> tha | t I last saw t   | the deceased              |
| alive an_O_i   | Sep 6. 192   | and that death                   |   |                                |                       |                  | tated abave.              |
| ACTUAL   | 9111 1   | - 4 - 4                          |   | ADDRESS (Street, cit           |                       |                  |                           |
| SIGNATURE  | XID VV   | very                             | M.D. U.S. Nava                            | I Hospit                       | ar, Be.               | thesda,          | Ma.9-7-                   |
| PHYSICIAN'S  |  | - walt                           | TT (2 ) 17                                | 7 77 1 4                       | D                     | h                | 34.3                      |
| NAME (Type) G  | B, AVERY, L'   | r MC(JUSN                        | U.S. Nava                                 | т новрти                       | al, Be                | tnesda           | Ma.                       |
| 220. BURIAL, CREMATIO  | 9-9-59   | 22c. NAME OF CEMETERY CAPLINGTON |   | 22d. LOCATION (C               |                       |                  | (Stote)                   |
| 23. FUNERAL DIRECTOR   | S SIGNATURE LET CIL  | WADDRESS X14                     | 240. REC'                                 | BY REGISTRAR                   | 24b. REGISTRA         | R'S SIGNATURE    |                           |
| Chambers   | Funeral Home   | e 517 11th/S                     | t. SE, Wash                               | ington                         | D.G.                  |                  |                           |
|  |  |                                  | DATE                                      | 9 159                          | Cai                   | Pun & France     | u.el                      |

VS A1S (4) 1SM 9/SB

|                  | TOTAL DESIGNATION OF THE PART |             |                  |       |
|------------------|---|-------------|------------------|-------|
|                  |   |             |                  |       |
|                  | Newwood to delevation   |             | - Various        | 1031  |
|                  | No of Angelon - Angelon   | aysh -      | (Janus) social   |       |
|                  | d. 627 Jamesager St. 8  | M estremand | . Kawal Hospitaa | E.U   |
| carber o raders  | deg ANDRIA  | noulbaM     | Yelsy            |       |
|                  | 2-1 May 1956 3  |             | bound            |       |
| 8.0.             | ListeR  |             |                  |       |
|                  | J. MOUGEN WOVE  |             | MICHIEN HOW WAS  | inia- |
| XI.              |   |             |                  |       |
|                  |   |             |                  |       |
|                  | .Topi a gi a  | an It       | 6 Sept.          |       |
| -9.Ni.shoshtafi, | Latingon Leyen S.D  | Jan A       | · •              |       |
| Bethemos, Kd.    | U.S. Thewall Houses to  | En los de   | G. P. AVERY,     |       |
| oinigaly .       |   |             |                  |       |

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10479

#### CERTIFICATE OF DEATH

215

|                                       | 70313   | 0=111111                         |  |                                   | Reg. Dist. No. 417   |
|---------------------------------------|---|----------------------------------|--|-----------------------------------|--|
| . PLACE OF DEATH                      |   |                                  | a STATE  |                                   | ion: Residence before admission)                           |
| Montgon                               | nery  | MARYLAN                          | Maryland   | Prin                              | ce Georges   |
| b. CITY OR TOWN                       | (If outside corporate limits, nearest town)   | write c. LENGTH OF STAY IN 1     | b c. CITY OR TOWN (If  | autside corporate limits, write R |  |
| Betheso                               | la (Rural)  | DOA                              | Hyattsvi]  | lle /                             | 615-2  |
| OR INSTITUTIO                         |   |                                  | d. STREET ADDRESS  | 04 17 - 4                         | e. IS RESIDENCE<br>ON A FARM?                              |
|                                       | laval Hospit  | al                               | 5719 29th  |                                   | YES NO   |
| 3. NAME OF<br>DECEASED                | First   | Middle                           | Last   | 4. DATE Man                       | /  |
| (Type or print)                       | Ruth  | Nelson                           | MOORE  |                                   | ember 15 1959  |
| 5. SEX                                | 6. COLOR OR RACE 7.   | · MARRIED 🔀 NEVER MARRIED [      | B. DATE OF BIRTH   | 9. AGE (In years lqst birthday)   | Months Doys Hours Min.                                     |
| Female                                | Caucasianw  |                                  | 7-1  | 47 yrs.                           | Mill.  |
| 10a. USUAL OCCUPA<br>during most of w | TION (Give kind of work don<br>orking life, even if retired)  | ne 10b. KIND OF BUSINESS OR IN   | IDUSTRY 11. BIRTHPLACE (Stote                                  | or foreign country)               | 12. CITIZEN OF WHAT COUNTR                                 |
| Housewif                              | e   |                                  | New Yo   | ork                               | U.S.A.   |
| 3. FATHER'S NAME                      |   |                                  | 14. MOTHER'S MAIDEN I  | NAME                              |  |
| Chester                               | NELSON  |                                  | Charlotte  | DIETZ                             |  |
| 15. WAS DECEASED E                    | VER IN U. S. ARMED FORCES   | S? 16. SOCIAL SECURITY NO.       | INFORMANT  | Add                               | ress   |
| No                                    | (17 yaz, gra war ar adras ar raint  |                                  | H) Geo. L. N   | Moore, same                       | as #2 ahove  |
| 1B. CAUSE OF E                        | DEATH [Enter only one couse   | per line for (o), (b), and (c).] |  | 10010j Dane                       | INTERVAL BETWEEN   |
| PART I. C                             | EATH WAS CAUSED BY:   | Bronchopneumo                    | nia  |                                   | ONSET AND DEATH  |
| 1999                                  | 11111111111111111111111111111111111111  | Anaplastic ca                    |  | a undetermi                       | ned  |
| 199.2                                 |   | with widespre                    |  |                                   | brain  |
| Conditions, if                        |   |                                  |  | egimi ou ca                       | DIAIII   |
| couse (o), stoti                      | ng the under- DUE TO  | and abdominal                    | . organs   |                                   |  |
| lying cause lo                        |   |                                  |  |                                   | 1                    |
| CATIC                                 | THER SIGNIFICANT CONDIT   | IONS CONTRIBUTING TO DEATH       | BUT NOT RELATED TO THE TERM                                    | INAL DISEASE CONDITION GIV        | VEN IN PART 1(a) 19. WAS AUTOPSY<br>PERFORMED?<br>YES X NO |
| OR CONTRIBUTION                       | WAS UNDERLYING 20<br>NG CAUSE OF DEATH<br>FY MEDICAL EXAMINER)  | b. DESCRIBE HOW INJURY OCCU      | RRED. (Enter noture of injury in                               | Port I or Part II of item 1B.)    |  |
|                                       |   | 20.                              | DIACE OF INTURY AT   | Loos voi                          |  |
| 20c. TIME OF INJ                      | 1.  | While Not while                  | PLACE OF INJURY (Hame, form factory, street, affice bldg., etc | i.)                               | (Caunty) (State  |
|                                       |   | of work of wark                  |  |                                   |  |
| 21. I certify                         | that I attended the de  | eceased from May 26              | 19.59, to Se   | pt. 15 , 159.                     | that I last saw the decease                                |
|                                       |   |                                  |  |                                   | nd an the date stated abov                                 |
|                                       | 0 1. 9  | 00 0                             |  | ADDRESS (Street, city or town,    | stote) DATE SIGN   |
| SIGNATURE                             | autre .   | Clarke                           | M.D. U.S.  | Naval Hospi                       | tal 9-15-59  |
|                                       |   |                                  |  |                                   |  |
| PHYSICIAN'S<br>NAME (Type)            | . E. CLARKE   | LCDR, MC, I                      | ISN Bethes   | da. Maryland                      | d  |
| 220. BURIAL, CREMA                    | ION, 22b. DATE THEREOF  | 22c. NAME OF CEMETER             |  | 22d. LOCATION (City, town,        |  |
| REMOVAL (Speci                        |   |                                  | Cemetery   |                                   | . Maryland   |
|                                       | DR'S SIGNATURE O. D. 2  |                                  |  |                                   | STRAR'S SIGNATURE  |
| W F Plime                             | hnow Punons   | al Home. Silve                   | m Comingues S  |                                   | relun S. Mraus   |
| TT A E A A I LAILLE.                  | THE COUNTY OF THE PARTY OF THE | I INCHES A TO VE                 | "I" STITE I TOURIE V   |                                   |  |

TO HOSPITAL CA ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hour death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove perhaps pages? Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours often death.

MCGME THE SECTION TO BE SECTION TO BE SECTION TO SECTIO THE STATE OF THE S (II) Cec. L. Hoore, Ditto as (2 sboye Erchonognoumunia Knaplastic ostoinuma, site undeverwippi, with widespread movestages to lung, brain

Land of Land Colored Land Colored Colo William P. B. Starke, LCDH, EC. USH Hebblesds, Maryland

Burtal - 9-19-59 / Particleton Sometery | Heaville, Haryland

of Livestanti

100 M.E. Ponginger Street & Steen Street Spring - Front Street Street

24b. REGISTRAR'S SIGNATURE

arilan S. Kraus

24a. REC'D BY REGISTRAR

DATSEP

8 '59

|   | 10480  | CEKI   | IFICA            | TE OF DEAT   | Н             |                                     | Reg. D     | ist. No   | ١.        |                    |
|---|--|--|------------------|--|---------------|-------------------------------------|------------|-----------|-----------|--------------------|
| n. COUNTY  Montgome   | Prv  | MAR  | YLAND            | 2. USUAL RESIDENCE (W<br>o. STATE<br>Alabama               | here decease  | ed lived. If instituti<br>b. COUNTY | on: Reside | ence befo | re admis  | sion)              |
|   | (If outside carporote limits, s                            | write c. LENGTH OF STAT                              | Y IN 1b          | c. CITY OR TOWN (IF  | outside corp  | prote limits, write R               | URAL ond   | give ne   | arest tow | n)                 |
| Bethesda  |  | 7 days   |                  | Birminghan   | 1             | 11.0                                | 2 X -      | 3         |           |                    |
|   | ITAL (If not in hospitol, give                             | street address) Bethesda 14.                         | Md.              | d. STREET ADDRESS 42 Edgehil                               | l Roa         | d                                   |            |           | ON        | SIDENCE<br>A FARM? |
| NAME OF<br>DECEASED   | First  | Middl  | e                | Lost   | 4. DATE       | Man                                 | th         | Do        | 24        | Year               |
| (Type or print)   | Ray  | Clarence   | e                | Mork   | OF<br>DEATH   | Septe                               | mber       |           |           | 19 59              |
| . SEX   | 6. COLOR OR RACE 7.  | MARRIED NEVER MARR                                   | IED 🔲 8          | . DATE OF BIRTH  |               | 9. AGE (In years                    |            |           | IF UND    | ER 24 HRS          |
| Male  | White w  | IDOWED DIVORC  | ED 🔲             | January 8.   | 1900          | last birthdoy) 59 yrs.              | Months     | Days      | Hours     | Min.               |
| Oa. USUAL OCCUPAT   | ION (Give kind of wark dan<br>rking life, even if retired) | e 10b. KIND OF BUSINESS                              | OR INDUS         | TRY 11. BIRTHPLACE (State                                  | or fareign o  |                                     | 12. C      | TIZEN C   | F WHAT    | COUNTR             |
| Adminis   | trator   | Medical Jou  | rnal             | Wiscor   | nsin          |                                     |            | U.        | S. A      |                    |
| 3. FATHER'S NAME  |  |  |                  | 14. MOTHER'S MAIDEN  |               |                                     |            |           |           |                    |
| Reuben N  | lork   |  |                  | Clara  | Kitte         | elgon                               |            |           |           |                    |
|   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO              | *  | estiv            | e heart fail   | ure           |                                     |            | LIAIT     | FD1444 D1 |                    |
| Conditions, if gove rise to couse (o), stating lying couse lost | immediate ( DUE TO   | netto Heart I  | dispa            |  |               | ufficience<br>origin                | y 0        | f         | 15 3      | rears              |
| N N N N N N N N N N N N N N N N N N N                           |  | IONS <u>CONTRIBUTING</u> TO DE                       | EATH BUT I       | NOT RELATED TO THE TERM                                    | INAL DISEAS   | E CONDITION GIV                     | EN IN PA   | RT 1(o) 1 | PERFC     | AUTOPSY<br>ORMED?  |
| O HETHER, NOTIFY  | MEDICAL EXAMINER)  | DESCRIBE HOW INJURY (                                | OCCURRED         | . (Enter noture of injury in                               | Part I or Par | t 11 of item 18.)                   |            |           |           |                    |
| 20c. TIME OF INJU<br>Hour a. m.<br>p. m.                        |  | 20d. INJURY OCCURRED While Nat while of work at wark | fact             | CE OF INJURY (Hame, farm<br>ary, street, office bldg., etc | 20f. (City    | or tawn)                            |            | (County)  |           | (State)            |
| 21. I certify to  | hat I attended the de<br>September 1                       | 20   | ust 2<br>t death | accurred at 10:1   | PM, fran      | , .,                                | nd an i    | last so   | te state  | deceased abov      |
| ACTUAL<br>SIGNATURE   | Intal 40.  | Sidel  | N                | The  | Clin          | ical Cent                           | er         | בוריים    | 9-        | 2-59               |
| PHYSICIAN'S V:  | ictor W. Side  | 1, M.D.  | -                |  |               | Institut                            |            | I He      | alth      |                    |
| 20. BURIAL, CREMATIC<br>REMOVAL (Specify                        | ON, 22b. DATE THEREOF                                      | 22c. NAME OF CEM                                     |                  |  | 1             | rion (City, tawn, o                 | ,,         |           | (Stot     | e)                 |

TO FUNERAL DIV TO HOSPITAL VS A15 (4) 15M 10/57

the registror prior

23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines

deoth: Poge 4 unerol director,

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours

this certificate has been signed by the ottending physician and completely filled in

toched for use as the burial-transit permit. Then please remove copban popers. burial, cremation, or removal, and in any event within 72 hours effer death.

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VS A15 (4) 15M 10/57

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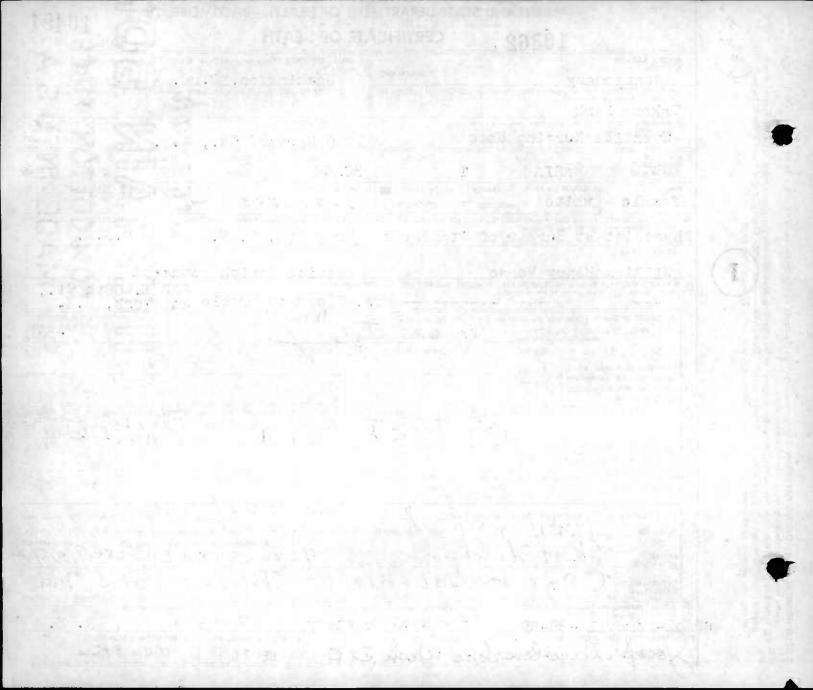
CERTIFICATE OF DEATH

|   | 10487  | CERTIFICA                  | TIL OI DEAL   |                          |   | Reg. Dist.   | . No.         |           |
|---|--|----------------------------|---|--------------------------|---|--------------|---------------|-----------|
| a. COUNTY                                 | Montgomery   | MARYLAND                   | 2. USUAL RESIDENCE (VO. STATE                         | Where deceased           | b. COUNTY                               |              | before odm    |           |
| RURAL and give no                         | _  | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (II                                   |                          | rote limits, write R                    | URAL ond giv | ve nearest to | wn)       |
|   | Iney  [AL (If not in hospital, give street)  | oddress)                   | d, STREET ADDRESS                                     | lney                     |   |              | e. IS R       | ESIDENCE  |
|   | County General   | Hospital, Inc              | 1   | 08 Kin                   | g William                               | Drive        | Name 1        | A FARM?   |
| NAME OF<br>DECEASED<br>(Type or print)    | First  | Middle                     | Lost  | 4. DATE<br>OF<br>DEATH   | Mon                                     | th           | Day           | Year      |
| S. SEX                                    | Nellie   | Frances                    | Morley  | DEATH                    | 9 405 (15 115 115                       | IE HNIDER 1  | YEAR IF UN    | 19 5      |
| Female                                    | 6. COLOR OR RACE 7. MAR WIDOW  |                            | 8. DATE OF BIRTH 3.28.188                             | 7                        | 9. AGE (In years last birthdoy) 72 yrs. |              | Days Hour     |           |
| 00. USUAL OCCUPATIO                       | ON (Give kind of work done 10b. king life, even if retired)  | KIND OF BUSINESS OR INDU   |   |                          | ountry)                                 | 12. CITIZ    | EN OF WHA     | AT COUNT  |
| Housewif                                  |  |                            | Irelan  | nd                       |   |              | U.S.          | A         |
| 3. FATHER'S NAME                          |  |                            | 14. MOTHER'S MAIDEN                                   | NAME                     | 15 3-41 To                              | - 11.1       | 713 9         | ====      |
| Denis                                     | 0'Neill  |                            | Cath  | erine I                  | Downing                                 |              |               |           |
| 5. WAS DECEASED EVE                       | R IN U. S. ARMED FORCES? 16.   | SOCIAL SECURITY NO. 17. I  | NFORMANT  | 01220 1                  | Addi                                    | ress         |               |           |
| (Yes, no, or unknown)                     | (If yes, give war or dates of service)   |                            | II a aud 4 a  | 7 Dec                    | - d -                                   |              |               |           |
| In CAUSE OF DE                            | THE CO. LANSING THE PARTY OF TH |                            | Hospita   | r Keco                   | rus                                     |              | LINITEDVAL    | DES14/EE. |
|   | ATH [Enter only one couse per li<br>ATH WAS CAUSED BY:   | ine for (o), (b), and (c). |   |                          |   |              | ONSET, AN     | D DEATH   |
| OL OL                                     | IMMEDIATE CAUSE (o)  | Inenition                  |   |                          |   |              | 6             | mos.      |
| 100,0                                     | DUE TO   |                            | 11  |                          |   |              |               |           |
| Conditions, if o                          | ny, which ) (b)  | Chronic Ar                 | -thritis  |                          |   |              | 5             | Line      |
| gove rise to i                            | mmediate (   |                            |   |                          |   |              |               | 7.0       |
| lying cause last.                         | ine onder-   |                            |   |                          |   |              |               | '         |
|   | (c)  | CONTRIBUTING TO DEATH BUT  | NOT BELLIED TO THE TER                                | AND DICEASE              | CONDITION OF                            | C I B B.     | 14 1 10 144   | V38OTH 3  |
| PART II. OII                              | HER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TER                                | MINAL DISEAS             | E CONDITION GIV                         | EN IN PART   | PER!          | FORMED?   |
| 5   |  |                            |   |                          |   |              | YES [         | ] NO [    |
| OR CONTRIBUTING                           | AS UNDERLYING   20b. DES   | SCRIBE HOW INJURY OCCURRE  | D. (Enter nature of injury i                          | in Port 1 or Pari        | t 11 of item 1B.)                       |              |               |           |
| 20c. TIME OF INJUR<br>Hour a. m.<br>p. m. | RY Month, Doy, Year 20d. While at wo   | _ Not while fa             | ACE OF INJURY (Home, foctory, street, affice bldg., e | orm, 20f. (City<br>etc.) | or town)                                | (Co          | ounty)        | (Stote    |
| 21 Learning the                           | nat I attended the deceas  | sed from 19.58             | , 19, to  | Jept                     | 4 10 59                                 | that I !-    | and court at  | a dasse-  |
| , C                                       | and i difference ine deced   |                            |   |                          |   | _,that I la  |               |           |
| alive an                                  | , 19   | , and that death           | accurred at 5:00                                      |                          |   |              |               |           |
| ACTUAL K                                  | 7 . 1  | 11.00                      |   | WDDKF22 (2)              | reet, city or town,                     | stole)       |               | DATE SIGN |
| SIGNATURE                                 | which U  | . Jew mp                   | M.D   |                          |   |              | 91            | 5/5       |
| PHYSICIAN'S<br>NAME (Type)                | Richard A. Ya  | ites, M. D.                | Oln   | ney. Maj                 | ryland                                  |              | 9.            | 5.59      |
| PO GURIAN CREMATIC<br>REMOVAL (Specify)   | N; 22b_DATE THEREOF  | Pate of Hear               |   |                          | NON (City town, o                       | Ma           |               | ofely     |
| 23. FUNERAL DIRECTOR                      | 'S NGNATURE /  | ADDRESS O                  |   | C'D BY REGIST            | PAR TAN PEGI                            | STRAR'S SIGN | VATURE        |           |
| 11/11/169                                 | tu de la   | 3831- 1                    | 7. NII 1  |                          |   | ribur &      | Thous         |           |
| 1 mm                                      | my tuncion   | 0001 -4 0                  | DATE  | A 201                    |   |              |               |           |

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| .t.e And         | Class. Maxy           | .a.e.           | Maria Richard Carolli  |
| title Miles to   |                       |                 |  |
| 17               |                       | 33.51 24 23     |  |

Reg. Dist. No.

|               | o. COUNTY                              |  |                         |                             | 2. USUAL RESIDE                         | ENCE (Where deceo     |                     | f institution: | Residence before               | e odmission)   |
|---------------|--|--|-------------------------|-----------------------------|---|-----------------------|---------------------|----------------|--------------------------------|----------------|
| L             | Montgo                                 |  |                         | MARYLAND                    |   | nington,              | D.                  | C              | 2291                           |                |
|               | RURAL ond give r Takoma                |  | ts, write c. LENGT      | H OF STAY IN 16             | c. CITY OR TO                           | OWN (If outside cor   | porote limits       | , write RUR    | AL and give near $7 \times -3$ | rest town)     |
| -             | d. NAME OF HOSP                        | TAL (If not in hospital, a                                 | ive street oddress)     |                             | d. STREET AD                            | DRESS                 |                     |                |                                | . IS RESIDENCE |
|               | Evention<br>Evention                   | de Nursing   | g Home                  |                             | 1750 H                                  | arvard S              | t.,                 | N.W.           |                                | ON A FARM?     |
| 3.            | NAME OF<br>DECEASED<br>(Type or print) | MARIA  | I,                      | Middle                      | MORSE                                   | 4. DATE<br>OF<br>DEAT |                     | Month          | Doy<br>2 5                     | -              |
| S.            | female                                 | 6. COLOR OR RACE white                                     | 7. MARRIED NE           | DIVORCED                    | 6 - 27                                  | -1883                 | 9. AGE (<br>lost bi | rthdoy) A      | Months Doys                    | Hours Min.     |
| -             | during most of wo                      | ON (Give kind of work rking life, even if retired at Bures |                         | BUSINESS OR INDI<br>andards | Brook                                   |                       | 22                  |                | U.S.A                          | WHATCOUNTRY    |
| 13.           | FATHER'S NAME                          |  |                         |                             | 14. MOTHER'S A                          | MAIDEN NAME           |                     |                |                                |                |
|               | William                                | Henry Mo   | nge                     |                             | Louis                                   | se Paris              | h To                | mser           | nđ                             |                |
|               |  | ER IN U. S. ARMED FOR<br>(If yes, give wor or dates of s   | CES? 16. SOCIAL SE      |                             | INFORMANT                               |                       |                     | 333 New        | E. 68th                        | St.,           |
| -             | 18. CAUSE OF DE                        | ATH   Enter only one co                                    | use per line for lo), ( |                             |   |                       |                     | 21011          | INTE                           | RVAL BETWEEN   |
|               |  | ATH WAS CAUSED BY:   | Mno                     | duname                      | Tues o                                  |                       |                     |                | ONS                            | ET AND DEATH   |
|               | 492 x                                  | IMMEDIATE CAUSE (o   | 02                      | banna - 0                   | ten                                     |                       |                     |                |                                | <del>()</del>  |
|               | /                                      |  |                         |                             |   |                       |                     |                |                                |                |
|               | Conditions, if                         |  | 1                       |                             |   |                       | -                   |                |                                |                |
|               | couse (o), stoting                     | the under-   |                         |                             |   |                       |                     |                |                                |                |
| 1-            | lying couse lost                       | , (0   |                         |                             |   |                       |                     |                |                                |                |
| CERTIFICATION | PART II. OT                            | HER SIGNIFICANT CON  | DITIONS CONTRIBUT       | Ind and                     | thut related to                         | 1 3- 11 .             | ASE CONDI           | 1              | IN PART (6)                    | PERFORMED?     |
|               | OR CONTRIBUTING                        | AS UNDERLYING  G CAUSE OF DEATH MEDICAL EXAMINER)          | 206. DESCRIBE HOW       | V INJURY OCCURR             | ED. (Enter noture of                    | injury in Port I or P | ort II of ite       | m 18.)         | rigation                       |                |
| MEDICAL       | 20c. TIME OF INJU<br>Hour o.m.<br>p.m. | RY Month, Doy, Yes   | While Not work of work  | while fo                    | LACE OF INJURY (Hoctory, street, office |                       | ity or town)        |                | (County)                       | (Stot          |
|               | 21. I certify t                        | hat j attended the   | deceased fram           | Jen                         | 1940                                    | to 9/24               |                     | 193 18         | at I last saw                  | the decease    |
|               | alive an                               | 9/24/  | 3 /1                    | //                          | h accurred at                           | :45 A.M from          | n the car           | ises and       | an the date                    | stated abov    |
|               |  | .00  | 100                     | and mar addition            |   |                       |                     | or town, sto   |                                | DATE SIGN      |
|               | ACTUAL<br>SIGNATURE                    | - 1 - 1 ·  | Holeton                 | <u> </u>                    | M.D. 97                                 | 600 0                 | J. J.               | 0 1_           | LIVC                           | 4/25/          |
|               | PHYSICIAN'S<br>NAME (Type)             | Chas   | 14 VV                   | oLott                       | 6 /                                     | lak                   | oM                  | 21             | ork                            | md,            |
| 220           | REMOVAL (Specify                       | 22b. DATE THEREO   | ~                       | me of cemetery of           | or CREMATORY<br>Cemetery                |                       | CATION (CIT         | y, town, or    | county)                        | (Stote)        |
| 23            | FUNERAL DIRECTO                        |  |                         | RESS Whale.                 |   | 24a. REC'D BY REG     |                     |                | Lug & Kra                      |                |
| 1             | 7-10                                   | ,  | 70,00                   |                             | 1                                       | W New York            |                     |                |                                |                |



Not while

21. I certify that I oftended the deceased from AVG V ST

of work of work

7, that I last saw the deceased

ACTUAL

, and that deoth occurred of 4 A.M. from the couses and on the dote stated above.

ADDRESS (Street, city or town, stote)

PHYSICIAN'S NAME (Type)

220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)

Lews

22c. NAME OF CEMETERY OF EREMATORY

22d. LOCATION

(Stote)

23. FUNERAL DIRECTOR'S SIGNATURE

**ADDRESS** 2100

24a, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(City, town, or county)

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| E OF DEATH   | CERTIFICAL                |            |  |
|--|---------------------------|------------|--|
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| LACEURS T. Bernera LED   |                           | THE PERSON | L QX   |
|  | NATURAL<br>National       |            |  |
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| menterali servi tradit en 19,4 de 19 |                           |            |  |
|  |                           |            |  |
|  | ACTOR STREET, ST. ST. ST. |            |  |
| HUMBER (WOLLD) AS I MERCHANICATE AND INC.  |                           |            |  |

| MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE,  | 18 10453       |
|---|----------------|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE,  O S MEDICAL EXAMINER'S CERTIFICATE OF DEATH  Lem 22 Film G249 9/24/59 lwk | Reg. Dist. No. |
| 2 USUAL RESIDENCE (Where decoraed lived if institu  |                |

| 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)           |
|--|---|
| O. COUNTY MARYLAND   | 6. STATE OF 19 19 11 S. COUNTY PRINCE G-TORGO   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)                |
| Takoma Tark 9hrs.  | Mr. Ranger 1616-2   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
| Washing-Ton SaniTaRIUM Hospital  | 4004 29th ST YES NO.  |
| 3. NAME OF First Middle  | Last 4. DATE Month Day Year   |
| (Type or print) William John   | MURROUY DEATH 9 16 1959   |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8   |   |
| Male WIDOWED DIVORCED  | 10 - 27-1886 (2 yrs.)   |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUST during most of working life, even if retired)  | TRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                      |
| Disabled soldier U.S. Army   | New York york U.S.A.  |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
| James Murray   | Sophia Johnson  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II  | NFORMANT Address  |
| yes waldward none in   | 155 Mary Johnson 4004 29 the MT KANIER  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)   | a hummhane 10hm   |
| . 904.0 DUE TO   |   |
| Conditions, if ony, which) (b)   |   |
| gove rise to immediate cause (a), stating the underlying DUE TO  |   |
| couse lost. (c)  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I  | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?     |
| 3  | YES NO  |
| PRIMARY LI or CONTRIBUTING M   | inter nature of injury in Part 1 or Part II of item 18.)  |
|  | ere at home   |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA Hour o. m. 4-16 1957 of work of wor | CE OF INJURY (Home, form, 20f. (City or town) (County) (Slate) ory, street, office bldg., etc.) |
|  | home Int Rowner - 12.9. mel   |
| 21. I certify that I taak charge af the remains described aba  | ve, held an Autapsy [], Inspection . Inquiry , and find that                                    |
| death resulted from: Natural causes, Accident 💢, Sui   | cide 🔲, Homicide 🔲, Undetermined cause 🗍.   |
| ACTUAL A 10 B  | DATE SIGNED   |
| SIGNATURE VACUA OF DIOTETRAL   | _M.D. CHIEF MEDICAL EXAMINER  |
| EXAMINER'S PLANTER   | ASSISTANT MEDICAL EXAMINER \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                                |
| NAME (Type) FLANK J- 12 roschart   | DEPUTY MEDICAL EXAMINER 7 7 17-39   |
| 220. BURIAL, CREMATION, 22b. DAJE THEREOF 22c. NAME OF CEMETERY OR REMOVAL (Specify)   | Baltimore. Md.  |
| Burial 9/23/59 Arlangton/1   | at////cem. Ar/1/mgton//N/1/gywis  |
| The S.H. Hines Co. Washington, D   | 240. REC'D BY REGISTRAR 246, REGISTRAR'S SIGNATURE  |
| -110 - 111 THOS OF "ABILITIE COIL, D   | . C. DATESEP 2 2 '59 arthur & House   |

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VS A1S (4) 1SM 9/SB

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10483 CERTIFICATE OF DEATH

10454

FICATE OF DEATH Reg. Dist. No.

| 1. PLACE OF DEATH a. COUNTY  Montgomery   |  |  | м  | MARYLAND   | 2. USUAL RESI  | nessee  |  | lived. If in<br>b. CO  |                            | -                             | nce befa                 |                                | ian)                                |
|---|--|--|--|--|--|---|--|--|----------------------------|-------------------------------|--------------------------|--------------------------------|-------------------------------------|
| b. CITY OR TOWN (If as  |  | s, write   | c. LENGTH OF S   | TAY IN 1b  | -  | TOWN (If or   |  | ate limits, w  | vrite RU                   | RAL and                       | give nec                 | prest tawr                     | 1)                                  |
| RURAL and give neare<br>Bethesda  | sr idwn)   |  | 16 day   | 75   | LaF  | ollett  | ce   |  | 79                         | 9 x -                         | 3                        |                                |                                     |
| d. NAME OF HOSPITAL   | (If nat in haspital, gi  | ive street a   |  |  | d. STREET  | ADDRESS   |  |  |                            |                               |                          | e. IS RES                      | IDENCE                              |
| The Clinic  | al Center  | Bet  | hesda 11   | , Md.  | Rou  | te l  |  |  | 1                          | REST                          |                          |                                | NO 1                                |
| 3. NAME OF<br>DECEASED  | Firs   | it   | Mi   | iddle  | La   | st  | 4. DATE<br>OF  | 1000   | Manth                      | h                             | Do                       | ıy                             | Year                                |
| (Type ar print)   | Lore   | ne   |  | Na Desig   | Mye  | rs  | DEATH  | Sept   | temb                       | er                            | 1,                       | 5,                             | 19 59                               |
| 5. SEX 6.   | COLOR OR RACE  | 7. MARRII  | ED NEVER MA  | ARRIED [   | B. DATE OF BIRT  | Н   |  | 9. AGE (In last birth  | years                      |                               |                          |                                | ER 24 HRS                           |
| Female  | White  | WIDOWED  | DIVO   | ORCED [  | Decembe  | r 16.   | 1928   | 30   | yrs.                       | Months                        | Days                     | Haurs                          | Min.                                |
| 100. USUAL OCCUPATION   | (Give kind af wark d   | ane 10b. K   | IND OF BUSINE  | SS OR INDU   | STRY 11. BIRTHP  | LACE (State of  | ar fareign ca  | untry)   |                            | 12. CIT                       | IZEN OI                  | WHAT                           | OUNTRY                              |
| during most of working Housewife  | life, even if refired)   |  | None   | 9  |  | Tenn  | essee  |  |                            |                               | II.                      | S.                             | A .                                 |
| 13. FATHER'S NAME   |  |  | 110110   |  | 14. MOTHER'S   |   |  |  |                            |                               |                          |                                | ~~ •                                |
| Dock Adkin  | 6  |  |  |  |  | Minn  | ie Go  | a d  |                            |                               |                          |                                |                                     |
| IS. WAS DECEASED EVER IN  |  | FS2 14 S   | OCIAL SECURITY   | NO   | INFORMANT T  | he Med  |  |  | Addre                      | ntt                           | -                        |                                |                                     |
| (Yes, no, or unknown)   (If ye  | es, give wor or dates of se  | rvice)   |  |  |  |   |  |  |                            |                               | 3/6                      |                                |                                     |
| RI -  |  |  | 93-20-70   | 790  | The Clin   | ical (  | enter  | , beti   | 3030                       | 181 111                       | Ple Mie                  | ary                            | ina                                 |
| 18. CAUSE OF DEATH PART I. DEATH IM   | [Enter only ane cau<br>WAS CAUSED BY:<br>IMEDIATE CAUSE (a)<br>DUE TO  | use per line   |  |  | iac Arre   | st  |  |  |                            |                               | INT                      | ERVAL BE                       | TWEEN<br>DEATH                      |
| 18. CAUSE OF DEATH  PART I. DEATH IN  Canditians, if any, gave rise to imm cause (a), stating the lying cause last.   | WAS CAUSED BY: IMEDIATE CAUSE (a) DUE TO which ediate DUE TO   | Ope  Rhe   | rative -<br>umatic F   | - Card<br>leart<br>affici  | Disease  | Stene   | NAL DISEASE  | : CONDITIO   | DN GIVE                    | EN IN PAI                     | ON                       | LO TO                          | DEATH  DEATH  DEATH  AUTOPSY  DEATH |
| 18. CAUSE OF DEATH  PART I. DEATH IN  Canditions, if any, gave rise to imm cause (a), stating the lying cause last.  PART II. OTHER  20a. ACCIDENT WAS L OR CONTRIBUTING  (IF EITHER, NOTIFY ME   | WAS CAUSED BY: IMEDIATE CAUSE (a)  DUE TO  which (b) ediate under- SIGNIFICANT CONE  DIDERLYING  CAUSE OF DEATH DICAL EXAMINER)  | Rhe  Mit  Options CO  20b. DESCI   | matic F  | Card  leart  affici D DEATH BU  RY OCCURRI   | Di se ase  ency and T NOT RELATED TO   | Stendo THE TERMIN<br>of injury in P   | Part I ar Part   | II of item 1   |                            |                               | ON                       | LO TO                          | AUTOPSY<br>NO                       |
| 18. CAUSE OF DEATH  PART I. DEATH IN  Canditians, if any, gave rise ta imm cause (a), stating the lying cause last.  PART II. OTHER  20a. ACCIDENT WAS L OR CONTRIBUTING  (IF EITHER, NOTIFY ME   | WAS CAUSED BY: IMEDIATE CAUSE (a)  DUE TO  which (b) ediate under- SIGNIFICANT CONE  DIDERLYING  CAUSE OF DEATH DICAL EXAMINER)  | Rhe  Ope  Rhe  Ottoor  Cob. DESCI  | rative - umatic F  | Card  leart  affici D DEATH BU  RY OCCURRI   | Di se ase ency and t NOT RELATED TO  | Stendo THE TERMIN<br>of injury in P   | Part I ar Part   | II of item 1   |                            |                               | ON:                      | LO TO                          | DEATH                               |
| 18. CAUSE OF DEATH PART I. DEATH IN  Canditians, if any, gave rise to imm cause (a), stating the lying cause last.  PART II. OTHER  20a. ACCIDENT WAS L OR CONTRIBUTING  (IF EITHER, NOTIFY ME 20c. TIME OF INJURY Hour a. m. P. m.  21. I certify that olive on Sept  ACTUAL SIGNATURE PHYSICIAN'S   | WAS CAUSED BY: IMEDIATE CAUSE (a)  DUE TO  which ediate under.  DUE TO  SIGNIFICANT CONE  DIATE CAUSE OF DEATH DICAL EXAMINER)  Manth, Day, Yeo  19  1 ottended the ember 15   | Rhe  Ope  Rhe  Other  O | TRIBE HOW INJURY OCCURRED Nat while at wark of from Au   | Card  leart  O DEATH BU  RY OCCURRI  O 20e. Pr   | Di sease  ency and t Not related to  ED. (Enter nature of lace of INJURY actary, street, affic  30 , 19 59 h occurred at  M.D. Th  Na                      | Stene O THETERMIN  af injury in P  (Hame, farm, bldg., etc.)  , to Sec. 2:45 P                  | otembe  M, from the part of th | or tawn)  r 15 19 the cause reet, city or  Center  itutes      | 959,t<br>es onc<br>tawn, s | hot I k<br>d on th            | (Caunty) ast sove        | 9. WAS PERFO                   | AUTOPSY NO (State                   |
| 18. CAUSE OF DEATH PART I. DEATH PART I. DEATH IN  Conditions, if any, gave rise to imm cause (a), stating the lying cause last.  PART II. OTHER  20a. ACCIDENT WAS L OR CONTRIBUTING (IF EITHER, NOTIFY ME 20c. TIME OF INJURY Hour a. m. P. m.  21. I certify that olive on Sept  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)  RETAIL  22a. BURIAL, CREMATION, | WAS CAUSED BY: IMEDIATE CAUSE (a)  DUE TO  which ediate under:  SIGNIFICANT CONE  DIAMETER (b)  DUE TO  (c)  SIGNIFICANT CONE  DIAMETER (c)  MODERLYING TO  CAUSE OF DEATH DICAL EXAMINER)  Month, Day, Yeo  19  I ottended the ember 15 | Rhe Ope Rhe Ottlons co  20b. DESCI  r 20d. IN. While at wark decease , 19 D  | TRIBE HOW INJURY OCCURRED Nat while at wark of from Au   | Card  leart  O DEATH BU  RY OCCURRI  20e. Profes  agust  chat death  | Di se ase  ency and T NOT RELATED TO  ED. (Enter nature of LACE OF INJURY actory, street, affic  30 , 19 59 h occurred at  Na Be                           | Stene o THE TERMIN  of injury in P  (Hame, farm, te bldg., etc.)  to Sep 2:45 P  te Glin tional | otembe  M, from the part of th | or town)  r 15 15 the cause rest, city or Center itutes Maryla | 959,tes one tawn, s        | hot I led on the state)  Hea  | (Caunty) ast sove        | 9. WAS PERFO                   | AUTOPSY NO (State                   |
| 18. CAUSE OF DEATH PART I. DEATH IN  Canditians, if any, gave rise to imm couse (a), stating the lying cause last.  PART II. OTHER  20a. ACCIDENT WAS L OR CONTRIBUTING [IF EITHER, NOTIFY ME 20c. TIME OF INJURY Hour a. m. p. m.  21. I certify that olive on Sept  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Ken.   | WAS CAUSED BY: IMEDIATE CAUSE (a)  DUE TO  which ediate under:  SIGNIFICANT CONE  DIAMETER (b)  DUE TO  (c)  SIGNIFICANT CONE  DIAMETER (c)  MODERLYING TO  CAUSE OF DEATH DICAL EXAMINER)  Month, Day, Yeo  19  I ottended the ember 15 | Rhe Ope Rhe Ottlons co 20b. DESCI or 20d. IN. While at wark decease  | TRIBE HOW INJURY OCCURRED at wark at while of the month o | Centre Control | Di sease  ency and I NOT RELATED TO  ED. (Enter nature of  LACE OF INJURY rectary, street, affic  30 , 19 59  h occurred at  M.D. Th  Na  Be  DR CREMATORY | Stene o THE TERMIN  of injury in P  (Hame, farm, te bldg., etc.)  to Sep 2:45 P  te Glin tional | rat I ar Part  20f. (City  tembe  M, from I  ADDRESS (Str  1 11, 1  22d. LOCAT   | or town)  r 15 15 the cause rest, city or Center itutes Maryla | 959,tes once tawn, s       | that I lad on the state)  Hea | (Caunty) ast sove e dote | 9. WAS PERFOYES TO DATE (State | AUTOPSY<br>PRIMED?<br>NO (State     |

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TO HOSPITAL OF may be retain TO FUNERAL E

VS A1S (4) 1SM 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10484

**CERTIFICATE OF DEATH** 

Pag Dist No

|   | Reg. Dist. 110.  |
|---|--|
| 1. PLACE OF DEATH a. COUMEN T GOME T MARYLAND   | a. STATE Maryland b. COUNTY  |
| b. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest tawn)  Silver Spring   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)  7 Takoma Park                        |
| d. NAME OF HOSPITAL (If not in hospital, give street address)   | / d. STREET ADDRESS   e. IS RESIDENCE ON A FARM? YES □ NO □  |
| 3. NAME OF DECEASED (Type or print) Lillan Mary C   | Last OF Month Day Year OF DEATH September 20, 1959   |
| S. SEX  6. COLOR OR RACE  7. MARRIED TNEVER MARRIED WIDOWED DIVORCED DIVORCED   | 8. DATE OF BIRTH 6/6/80  9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.   Months   Days   Haurs   Min.          |
| 10a. USUAL OCCUPATION (Give kind af wark dane during most of working life, even if retired) HOUSEWIIE   | Baltimore, Md. U.S.A.  |
| 13. FATHER'S NAME Henry Meister   | 14. MOTHER'S MAIDEN NAME Louise Muhlstein  |
|   | arry O'Neil Silver Spring, Md.   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a) Pulmonary                               | mboliem Interval Between onset and Death   |
| Conditions, if any, which) (b) Carcinomate  | esis & mo.   |
| gave rise to immediate cause (a), stating the under-lying cause last.  DUE TO Primary Ade to  | no-Carcinoma of rectoin 10 mo.   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO Z                |
|   | D. (Enter nature of injury in Part I or Part II of item 18.)   |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Hour a. m. 19 While at work at wark   | ACE OF INJURY (Hame, farm, latary, street, office bldg etc.) (City or town) (County) (State)                           |
| 21. I certify that lattended the deceased from Dec 24 alive an 32 19 7, and that death  | n accurred at 12 PM, from the causes and an the date stated abave.  ADDRESS (Street, city or town, state)  DATE SIGNED |
| PHYSICIAN'S George L. Ball  | Silver Spring Md Sept 20   |
| 22c. NAME OF CEMETERY O COME HILL   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2900PRES14th St. Washington  | t. N.W. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  D. C. DATE SEP 2 2 '59                                     |

AND THE STATE OF THE PARTY OF T the state of the s a part and the

### FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is resssary, please execute the relicious, writing the ward "pending" in pendi in Item, 18. Give Pages 1, 2, and 3 to the funeral ectar. Page 4 should be corded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, ar remayal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Ren Dist No

| -             | 10/05  |   |                        |                               | meg. Dist. 110   | •                                      |
|---------------|--|---|------------------------|-------------------------------|------------------|--|
| 1.            | PLACE OF DEATH 10485 o. COUNTY MONTGOMERY MARYLAND   | 2. USUAL RESIDENCE (V                                   | Where deceased li      | ved. If institut<br>b. COUNTY |                  | fore admission)                        |
|               | b. CITY OR TOWN   If outside corporate limits, write RURAL ond give nearest town)  | c. CITY OR TOWN (I                                      | f outside corporat     | e limits, write               | RURAL and give n | eorest town)                           |
| 4             | SILVER SPRING 1 day  | COPP  | ERSBURG                | 7                             | 5 X - 3          |  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)   | d. STREET ADDRESS                                       |                        |                               |                  | e. IS RESIDENCE<br>ON A FARM?          |
|               | 10,020 MENLO AVENUE  | ROUTE #2  |                        |                               |                  | YES NO                                 |
| 3.            | NAME OF DECEASED (Type or print) FILI PEC  | CHACEK  | 4. DATE<br>OF<br>DEATH | SEPT .                        |                  | Yeor<br>159                            |
| 5.            | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B.   | DATE OF BIRTH   | 9. A                   | GE (In years                  | IF UNDER TYEAR   | IF UNDER 24 HRS.                       |
| L             | Latitude Hilliam Co Pr   | /6/80   |                        | 79 yrs.                       | Months Days      | Hours Min.                             |
| 10            | o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTI<br>during most of working life, even if retired)  | RY 11. BIRTHPLACE (Stote                                | or foreign countr      | у)                            | 12. CITIZEN O    | F WHAT COUNTRY                         |
|               | OWNER OF HOTEL (RETIRED) HOTEL   | CZECHOSLO   |                        |                               | U.S.A            |  |
| 13            | B. FATHER'S NAME   | 14. MOTHER'S MAIDEN                                     |                        | 40.00                         |                  |  |
| L             | JOSEPH JASEK   |   | unkn                   | own                           |                  |  |
| 1 1           | as no or reference t til use sine was as datas of services   | IFORMANT  |                        | Address                       |                  |  |
|               | NO none MLs  | ss Angela Pe  |                        |                               |                  |  |
|               | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  |   | Coppe                  | ersburg                       |                  | ET AND DEATH                           |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COTONARY  | occlusion   |                        |                               | S                | udden                                  |
|               | 420.1 DUE TO   |   |                        |                               |                  |  |
|               | Conditions, if ony, which) (b)   |   |                        |                               |                  |  |
|               | gove rise to immediate cause (a), stating the underlying DUE TO  |   |                        |                               |                  |  |
|               | couse last. (c)  |   |                        |                               |                  |  |
| CEPTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N  | OT RELATED TO THE TERM                                  | AINAL DISEASE CO       | NDITION GIVE                  |                  | 9. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
|               |  | nter noture of injury in Po                             | rt I or Part II of it  | em 18.)                       |                  |  |
| MEDICAL       | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLAC  | CE OF INJURY (Home, formary, street, office bldg., etc. | m, 20f. (City or to    | own)                          | (County)         | (Stote)                                |
| MED           | Hour o. m. p. m. 19 of work of work  | , , , , , , , , , , , , , , , , , , ,                   | "                      |                               |                  |  |
|               | 21. I certify that I took charge af the remains described abor   | ve, held an Autaps                                      | sy , Inspe             | ction 3.                      | Inquiry R        | , and in my                            |
|               | opinion death resulted from: Natural causes 1, Accident  | ☐, Suicide ☐.   | Homicide               | Undeter                       | mined manne      | r 🗇                                    |
|               |  | -d'   |                        |                               |                  |  |
|               | SIGNATURE Trans I. Browhart  | M.D. CHIEF MEDICAL E                                    | XAMINER                |                               |                  | DATE SIGNED                            |
|               | SIGNATURE STREETS & J. M. S. P. C. M. S. P. P. C. M. S. P. C. M. S. P. C. M. S. P. | ASSISTANT MEDIC   | CAL EXAMINER           |                               | 9/               | 26/59                                  |
|               | EXAMINER'S NAME (Type) FRANK J. BROSCHART  | DEPUTY MEDICAL  | EXAMINER               |                               |                  |  |
| 23            | 20. BURIAL CREMATION 1225, DATE THEREOF 1220, NAME OF CEMETERY OR  | CREMATORY   | 22d. LOCATION          | (City, town, o                | r county)        | (State)                                |
| 1             | TRANS. & BURIAL 9/30/59 CALVARY EMET   | ERY   | LIMEP                  | OST. PE                       | ENNSYLVAN        | JT A                                   |
| 2:            | TUNERAL DIRECTOR'S SIGNATURE Y, INC. SILVER SPRING   |   | 'D BY REGISTRAR        | 24b. REGIS                    | TRAR'S SIGNATUL  | RE                                     |
| 1             | ARNER E. PUMPHREY, INC. SILVER SPRING  | , MD. DASEP   | 28'59                  | arthu                         | 1 S. Thomas      |  |

BUSINA STREET, OCT, BECK - STANDER In missing accompet along the said .aa , madatan aa c The Court of the C THE TOLDHAND TO SEARCE ALL SEED

VS A1S (4) 1SM 9/S8

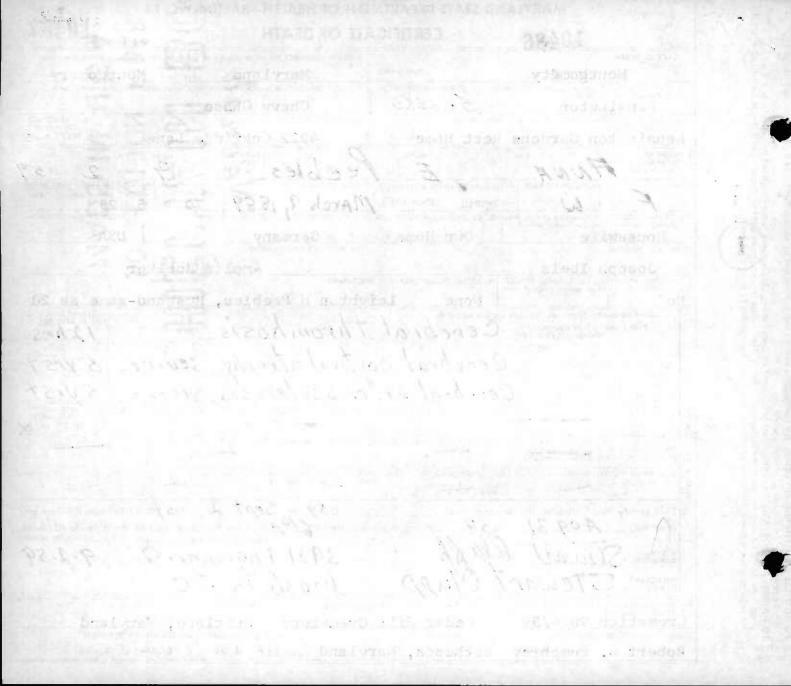
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10486

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 10457

| 1   | 1. PLACE OF DEATH g. COUNTY   | 3811.100.110             | 2. USUAL RESIDENCE (Where deceased lived   |   |
|-----|---|--------------------------|--|---|
| )   | Montgomety  | MARYLAND                 | o. STATE Maryland  | b. COUNTY Montgomery  |
|     | b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest tawn)                      | c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (If autside carporote li   |   |
|     | Kensington  | 5 WEEKS                  | X Chevy Chase  |   |
| -11 | d. NAME OF HOSPITAL (If not in haspital, give street as   | ddress)                  | d. STREET ADDRESS  | e. IS RESIDENCE   |
| 0   | Kensington Gardens Res  | sh Home                  | 4222 Oakridg   | ON A FARM? YES NO IX  |
|     | 3. NAME OF First  | Middle                   | D Lost 4. DATE   | Month Day Yeor  |
|     | (Type or print) FINNA   | EI                       | reebles OF DEATH   | 9 2 1959  |
|     | S. SEX 6. COLOR OR RACE 7. MARRIE   | ED NEVER MARRIED         |  | GE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. If birthdoy) Months Days Hours Min. |
|     | WIDOWED WIDOWED   | DIVORCED                 | mail a aca   | 70 yrs. 5 25 mours min.   |
| П   | 10a. USUAL OCCUPATION (Give kind af work done 10b. K<br>during most af working life, even if retired) | IND OF BUSINESS OR INDU  | STRY 11. BIRTHPLACE Stole or foreign country                                       | 12. CITIZEN OF WHAT COUNTRY?  |
|     | Housewife   | Own Home                 | Germany  | USA   |
|     | 13. FATHER'S NAME   |                          | 14. MOTHER'S MAIDEN NAME   |   |
|     | Joseph Ibels  |                          | Amelia   | Roelker   |
|     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SO   | OCIAL SECURITY NO.       | NFORMANT   | Address   |
|     | ,   | None Lei                 | ghton H Peebles,   | Husband-same as 2d  |
|     | 18. CAUSE OF DEATH [Enter only one couse per line   | for (a), (b), and (c).]  | gheon in recores,  | INTERVAL BETWEEN  |
|     | PART I, DEATH WAS CAUSED BY:  | enehnol                  | Throm hosis  | ONSET AND DEATH   |
|     | IMMEDIATE CAUSE (o)   | CICDIA                   | 11101100313  | 121113.   |
|     | 1   | no has la                | trans a transfer   | course Issued   |
|     | Conditions, if any, which gove rise to immediate (b)  | reprai Co                | rlical alrophy,  | SEVENE 3 YIS  |
|     | cause (o), stating the under-   | shool and                | eriosclerosis.   | selvence 511854   |
|     |   | E DI GI WIT              |  |   |
|     | PART II. OTHER SIGNIFICANT CONDITIONS CO  | ONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE COR  | PERFORMED?  |
|     |   |                          |  | YES NO X  |
|     | □ OR CONTRIBUTING □ CAUSE OF DEATH  | TIBE HOW INJURY OCCURRE  | D. (Enter noture of injury in Part I ar Part II of                                 | item 18.)   |
|     |   |                          |  | 2 4   |
|     | 20c. TIME OF INJURY Month, Day, Year 20d. INJ<br>Hour a. m. While at work                             | JURY OCCURRED 20e. PL    | ACE OF INJURY (Hame, farm, 20f. (City or ta<br>tary, street, affice bldg., etc.) ! | wn) (County) (State)  |
|     | p. m. 19 at work  | of wark                  |  |   |
|     | 21. I certify that I attended the deceased  | d from                   | 1954, to Sept 2  | , 19.5 Ithat I last saw the deceased  |
|     | alive an A 09 3/ 195  | and that death           | - 10   | causes and an the date stated above.  |
|     | - 100   | 1 / A                    | ADDRESS (Street,   |   |
|     | SIGNATURE SULVAN WILL   | (AB                      | M.D. 3921 Ingom  | and 9,2,59  |
| 7   | - × +   | Kli                      | M.D. STATES  |   |
|     | PHYSICIAN'S SECURAL   | Clapp                    | Wash 15 /  | 2.0   |
|     | 220. BURIAL, CREMATION, 22b. DATE THEREOF   | 22c. NAME OF CEMETERY O  |  | (City, town, ar county) (State)   |
|     | REMOVAL (Specify)   |                          |  |   |
|     | Cremation 98/4/59  23. FUNERAL DIRECTOR'S SIGNATURE   | Cedar Hill ADDRESS       | Crematory Suitl:   | 24b. REGISTRAR'S SIGNATURE  |
|     |   | thesda. Mar              |  | arthur & thousa   |



|    |         |          | I.E. UVSAAX | STATE TO     |              |  |
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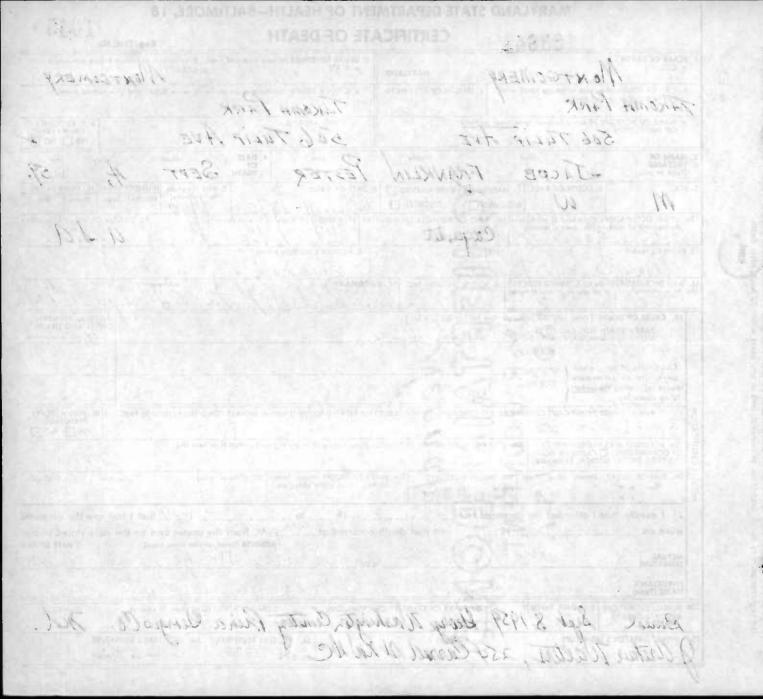
#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 10364

10459

|            | 10003   |  | Neg. Dist.                 | 140.                             |
|------------|---|--|----------------------------|----------------------------------|
|            | PLACE OF DEATH O. COUNTY  MONTGOMERY  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived o. STATE                                | If institution: Residence  | before admission)  COMERY        |
| 1          | b. CITY OR TOWN (If guyide corporate limits, write c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (If outside exporate lin   | nits, write RURAL and give | e nearest town)/                 |
|            | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 TULIP AVE  | 1 506 TULIP A  | VE                         | IS RESIDENCE ON A FARM? YES  NO  |
| 3.         | NAME OF DECEASED (Type or print)  TACPB FRANKLIN  | PESTER 4. DATE OF DEATH OF   | Month A                    | LDay Year 1959.                  |
| L          | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED  | Theren 11-1870 10st  |                            | EAR IF UNDER 24 HRS.             |
| 100        | u. USUAL OCCUPATION (Give kind of work done of the strength of working life, even if retired)  Clupustor  Clupustor                     | DISTRY 11. BIRTHPLACE (Stote or foreign country)                                 | Leis. 12. CITIZE           | OF WHAT COUNTRY?                 |
| 13.        | I'm. Havey Poster.  | 14. MOTHER'S MAIDEN NAME   |                            |                                  |
| 15.<br> Ye | WAS DECEASED EVER IN U. S. ATMED FORCES? 16. SOCIAL SECURITY NO. 17. s. no. or unknown] [If yes, give weet or dates of service]         | EN Pearl 1. Pextor   | 506 July                   | e the let                        |
|            | 18. CAUSE OF DEATH [Enter only one couse per line for (o). (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bronchopene | el mitorita  |                            | INTERVAL BETWEEN ONSET AND DEATH |
|            | 491 X DUE TO Conditions, if ony, which ) (b)  |  |                            | J                                |
|            | gove rise to immediate couse (a), stating the under-lying couse lost.   |  |                            |                                  |
| CATION     | Severe Prenicious Contributing to DEATH BU  | T NOT RELATED TO THE TERMINAL DISEASE CON  | DITION GIVEN IN PART 1     | PERFORMED?                       |
| L CERTIFI  | 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                  | ED. (Enter noture of injury in Port I or Port II of i                            | tem 18.)                   |                                  |
| MEDICAL    | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 40e. Pl While Not while of work of work 19                                    | LACE OF INJURY (Home, form, 20f. (City or tow clary, street, office bldg., etc.) | vn) (Cou                   | inty) (State)                    |
|            | 21. I certify that I attended the deceased from alive an 1959, and that death   | 19.59, to Sept 4<br>h accurred at 1100 p.M. from the                             |                            |                                  |
|            | ACTUAL SIGNATURE RUSSIELB, amala  | M.D. 880/ Coles Ville  |                            | DATE SIGNED                      |
|            | PHYSICIAN'S Russell B. Arnold M.  | D. Silver Sprin  | ng, md                     | ,                                |
| 220        | BURIAL CREMATION, 224-DATE THEREOF 220-MAME OF CEMETRY CONTROL (Symposity) Sight. 8, 1959 Storge Was                                    | proceeding ( Line 127)   | Riorges Co                 | (Stote)                          |
| 23         | MUNERAL DIRECTOR'S SIGNATURE, 254 CARRYLL ST  | 24a. PE'D BY REGISTRAR PATE SEP 9 '59  | 246. REGISTRAR'S SIGN.     |                                  |

TO HOSPITAL OR Many be relaired by TO FUNERAL



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488 CERTIFICA

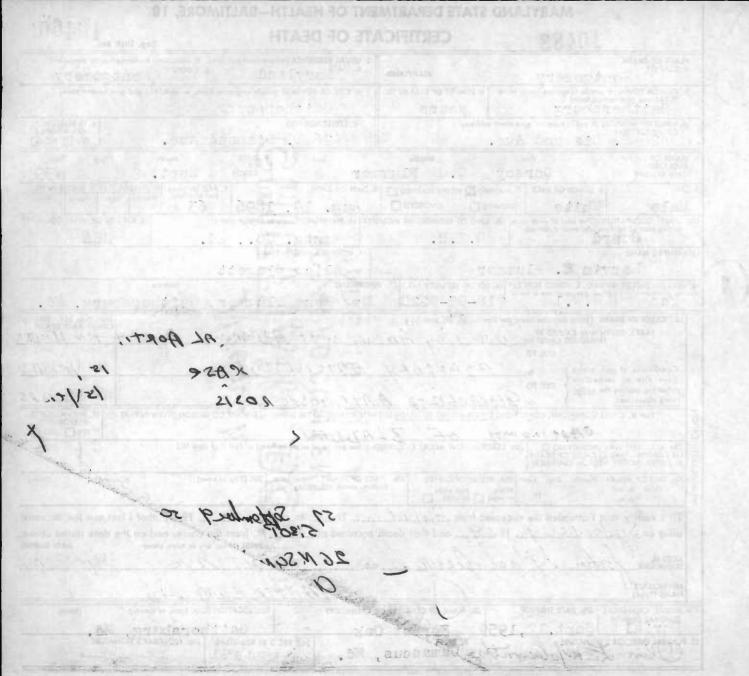
CERTIFICATE OF DEATH

10460

Rea. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY o. STATE Maryland b. COUNTY MARYLAND Montgomery Montgomery c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carporate limits, write c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) RURAL and give nearest town)
Gaithersburg Gaithersburg vears d. NAME OF HOSPITAL (If not in haspital, give street address)
OR, INSTRUCTION
426 E. Diamond Ave. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 426 E. Diamond Ave. YES NO NAME OF Middle 4. DATE Lost Month Day Year DECEASED C. Plummer Sent. 9 1959 Dorsev DEATH (Type or print) 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Haurs Min 8. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Male WIDOWED IT DIVORCED T 1896 White Aug. 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)

10b. KIND OF 8USINESS OR INDUSTRY 11. BIRTHPLACE (Stote or fareign cauntry) 12. CITIZEN OF WHAT COUNTRY? N.I.H. Montg. Co., Md. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Marvin E. Plummer Alice Clagett 17. INFORMANT IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address no, or unknown) Gaithersburg. Mrs Rena Plummer. INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO do NORDRY Canditions, if ony, which gave rise to immediate DUE TO catse (o), stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO CARCING MYA 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Hame, form, Day, Year 20d. INJURY OCCURRED 20f. (City ar tawn) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Nat while at work at wark 21. I certify that I attended the deceased from 1 Lithat I last saw the deceased and that death occurred at 3,301 M, from the causes and an the date stated above. ACTUAL PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, tawn, or county) (Stote) REMOVAL (Specify) Gaithersburg Forest Oak 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR Damascus. Md. arthur S. Kross



| 18                               | 10461                                     |  |  |  |  |  |
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| Reg. Dist. No. 215               |   |  |  |  |  |  |
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| 6x-3                             |   |  |  |  |  |  |
|                                  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO K |  |  |  |  |  |
| nth {                            | Day Year                                  |  |  |  |  |  |
| mber 1                           | 6 1959                                    |  |  |  |  |  |
|                                  | R IF UNDER 24 HRS.                        |  |  |  |  |  |
| Manths Days                      | Haurs Min.                                |  |  |  |  |  |
| 12. CITIZEN                      | OF WHAT COUNTRY?                          |  |  |  |  |  |
| U.S                              | S.A.                                      |  |  |  |  |  |
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|                | N U. S. ARMED FORCES?<br>es, give wor or dates of service)      | 16. SOCIAL SECURITY NO. None                    | Hospital R                 | lecords                   | Address  |
|                | WAS CAUSED BY: MEDIATE CAUSE (o)  DUE TO  which lediote  DUE TO | er line for (o), (b), and (c).] Congent Post of | al Heart start             | Desonie<br>(s) Aortic     | INTERVAL BETWEE ONSET AND DEAT                             |
| PART II. OTHER |   | NS CONTRIBUTING TO DEATI                        | H BUT NOT RELATED TO THE T | ERMINAL DISEASE CONDITION | N GIVEN IN PART 1(a) 19. WAS AUTO<br>PERFORMED<br>YES X NO |

MEDICAL

de

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Day,

o. m.

p. m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.)

20e. PLACE OF INJURY (Hame, form, 20f. (City ar tawn) factory, street, affice bldg., etc.)

(County) (State)

21. I certify that I attended the deceased fram August 26, 19 59, to Sept. 16, 159, that I last sow the deceased and that death occurred at 940PM, from the causes and on the date stated above. alive on Sept. ADDRESS (Street, city or town, stote) DATE SIGNED

ACTUAL

S. Naval Hospital

NAME (Type) Douglas R. KOTH. LCDR.MC.USN Bethesda, Maryland

20d. INJURY OCCURRED

at wark at wark

Nat while

22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) urial-Shipment

22d. LOCATION (City, town, ar caunty)

Carr

Ma

yrs

Septe

(State)

Wolfeboro New Hampshire 23 FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D 8Y REGISTRAR 24b. REGISTRAR'S SIGNATURE arthur S. Frank DATE SEP 21 Home, Bethesda, Md

VS A15 (4) 1SM 9/S8

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ond completely filled in by the funeral director, ben popers. Pages 1 and 2 should be filed with the haspitol or ottending physicion.

OR: After this certificate has been signed by the ottending physician page 3 shauld be detached for use as the burial-transit permit. Then please rem the registror priar ta burial, cremotion, ar removal, and in any event within 72 to moy be retain. If the haspitol or ottending physicion.

TO FUNERAL DI MOR: After this certificate has been signed by page 3 shauld be detached for use as the buriol-transit permit.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours, VS A15 (4) 1SM 9/SB MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10492 **CERTIFICATE OF DEATH** 

Reg. Dist. No. 215

| 1.            | PLACE OF DEATH o. COUNTY  | MARYIAND                   | 2. USUAL RESIDENCE (WH            |                          | If institution: Resid                | ence before admi   | ssion)             |
|---------------|---|----------------------------|-----------------------------------|--------------------------|--------------------------------------|--------------------|--------------------|
| /             | Montgomery  | MARYLAND                   | Maryland                          |                          | nn Arun                              | del                |                    |
|               | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)              | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (If o             |                          | s, write RURAL and                   | d give nearest tax | n)                 |
|               | Bethesda (Rural)  | 68 days                    | Annapolis                         |                          | 04-16                                | ) - ph             |                    |
|               | <ul> <li>d. NAME OF HOSPITAL (If not in hospital, give street<br/>OR INSTITUTION</li> </ul>   | oddress)                   | d. STREET ADDRESS                 |                          |                                      | e. IS RE           | SIDENCE<br>A FARM? |
|               | U. S. Naval Hospital  |                            | 1202 Pres                         | ident St                 | reet                                 |                    | NOT                |
| 3.            | NAME OF First DECEASED  | Middle                     | Lost                              | 4. DATE<br>OF            | Manth                                | Day                | Year               |
|               | (Type or print) George  | Perry                      | RASMUSSEN                         | DEATH S                  | eptembe                              |                    | 1959               |
| S.            | SEX 6. COLOR OR RACE 7. MAR   | RIED NEVER MARRIED         | B. DATE OF BIRTH                  | 9. AGE                   | (In years IF UNDE<br>irthday) Months | R 1 YEAR IF UND    | _                  |
| N             | lale ¢aucasian widow  | 'ED DIVORCED               | 9-23-99                           | 59                       | yrs. Months                          | Days Hours         | Min.               |
| 10            | a. USUAL OCCUPATION (Give kind af wark dane 10b during mast of working life, even if retired) | KIND OF BUSINESS OR INDU   | STRY 11. BIRTHPLACE (Stote        | or foreign cauntry)      | 12. Cr                               | TIZEN OF WHAT      | COUNTRY?           |
|               | Mariner   | U.S. Navy                  | Tennes                            | see                      |                                      | U.S.A.             |                    |
| 13            | FATHER'S NAME   |                            | 14. MOTHER'S MAIDEN N             |                          |                                      | 0.0.11.            |                    |
|               | Robert Rasmussen  |                            | Martha Gr                         |                          |                                      |                    |                    |
| 15            |   | SOCIAL SECURITY NO. 1      | NFORMANT                          | TOMOTO                   | Address                              | _                  |                    |
| ()            | es, no, or unknown)   (If yes, give war or dates of service)                                  | /1.7                       |                                   | A 70-                    |                                      |                    | 110                |
| -             | Yes   WWI & II  | ( W                        | Mrs. Mary                         | A. Rasm                  | ussen,                               | same as            | 3 #2               |
|               | 1B. CAUSE OF DEATH [Enter only one cause per I  | ine far (a), (b) and (c).] | 0                                 |                          | 11                                   | INTERVAL B         |                    |
|               | PART I. DEATH WAS CAUSED BY:  | von Baio cem               | a (porcurou                       | ra e uni                 | Jan leses                            | 150                |                    |
|               | 162.1 DUE TO  | 0                          |                                   |                          |                                      |                    |                    |
|               | Canditions, if ony, which )   |                            |                                   |                          |                                      |                    |                    |
|               | gove rise to immediate  |                            |                                   |                          |                                      |                    |                    |
|               | cause (o), stating the <u>under-</u>  |                            |                                   |                          |                                      |                    |                    |
| 7             | lying cause lost. (c)   |                            |                                   |                          |                                      |                    |                    |
| 9             | PART II. OTHER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERMI          | NAL DISEASE CONDI        | TION GIVEN IN PA                     | RT 1(a) 19. WAS    | AUTOPSY<br>ORMED?  |
| S             |   |                            |                                   |                          |                                      | YES D              | ■ NO □             |
| CERTIFICATION | 20g. ACCIDENT WAS UNDERLYING 20b. DES   | CRIBE HOW INJURY OCCURRE   | D. (Enter noture of injury in I   | Port I ar Part II of ite | m 1B.)                               |                    |                    |
|               | (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            |                                   |                          |                                      |                    |                    |
| N             | 20c. TIME OF INJURY Month, Day, Year 20d. I   |                            | ACE OF INJURY (Home, form         |                          |                                      | (County)           | (State)            |
| MEDICAL       | Hour o. m. While  | IAOI MINIE                 | ctory, street, office bldg., etc. | )                        |                                      |                    | , ,                |
| >             | p. m  |                            | FO 0                              | 074 12                   | FO                                   |                    |                    |
|               | 21. I certify that I attended the decea   |                            |                                   | ept. 13                  |                                      |                    |                    |
|               | alive an Sept. 12, 19   | 59, and that death         | accurred at 1:45                  | M, fram the car          | uses and an th                       | he date state      | d abave.           |
|               | MMI   |                            |                                   | ADDRESS (Street, city    | or town, stote)                      | DA                 | TE SIGNED          |
|               | SIGNATURE / 2 C To Muse   | N                          | M.D. U. S.                        | Naval Ho                 | spital                               | 9-74               | 1-50               |
| 1             |   |                            |                                   |                          |                                      |                    |                    |
|               | PHYSICIAN'S B. C. Johnson   | , LCDR, MC,                | USN Bethes                        | da 14, M                 | aryland                              |                    |                    |
| 22            | BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)  | 22c. NAME OF CEMETERY O    |                                   | 22d. LOCATION (Cit       | y, town, or caunty                   | ) (Sto             | ite)               |
| 6             | Burial 9-16-59  | Naval Acad                 | emy                               | Annapol                  | is                                   | Md.                |                    |
| 25            | FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                    | 24a, REC'I                        | D BY REGISTRAR 2         | 4b. REGISTRAR'S S                    | IGNATURE           |                    |
| 1             | ohn M. Taylor & Son.  | Annapolis, I               | DATE CE                           | P 1 6 '59                | arthur &                             | 9 45               |                    |
| L             | ATT IN TOL W DOLL   | AIMADOLIS, I               | Mu.                               | 1 0 00                   | Circuit 2                            | h, recourse        |                    |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1 0 4 0 5

| ESTABLEMENT OF OUR ATTENDED              | ALL OF REPUTE |                                 |                      |
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| aval Hompitel 9-17-59                    |               |                                 |                      |
| a, Murgiund                              | Jan Pulliand  |                                 | LIAN A MENER L. MALL |
| eshibity nethicket                       |               |                                 |                      |

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| his certificate shauld be executed within 24 haurs after death. If any delay is gecessary, please exe- | 1 "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral dic. Page 4 shauld be |              | ld be used as a burial-transit permit. File pegas, and 2 with the registrar prior to burial, cremation, |
|--|---|--------------|---|
| elay is necess   | I die   | files        | ar prior to bu  |
| th. If any de  | to the funera   | ned for your | th the registr  |
| urs after deal   | 1, 2, and 3 t   | may be retai | s ond 2 wi  |
| within 24 has  | Give Pages  | M3. Page 5   | nit. File pege  |
| be executed  | il in Item 18.  | with form P  | 1-transit perm  |
| icote should   | ing" in penci   | Office alang | ed as a buria   |
| is certif  | pued. p   | sminer's     | ld be use   |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10468 Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) PLACE OF DEATH

| o. COUNTY                              | mint                 | incer              | 1   | MARYLAND      | o. STATE                                   | md                     | b. COUNT                        | Monto            |   |
|--|----------------------|--------------------|---|---------------|--|------------------------|---------------------------------|------------------|---|
| b. CITY OR TOWN                        | (If outside corporat | timits, write RURA | c. LENGTH OF  | STAY IN 16    | c. CITY OR TO                              | WN (If outside cor     | porote limits, write            | RURAL ond give   | neorest town)                           |
| Sel                                    | Van A                | buy                | 2.1   | yn            | 56 Sel                                     | en Ap                  | ing                             |                  | To occupation                           |
| d. NAME OF HOS                         | PITAL OR INSTIT      | UTION (IF 10)      | in hospital, give street                            | bddress)      | d. STREET ADD                              | OV                     | 1,1                             | 0.4              | e. IS RESIDENCE<br>ON A FARM?           |
| Alther 1                               | Vursery              | Hme;               | -9301 Wes   | was ST        | 422  |                        | Hall                            | Rd               | YES NO                                  |
| NAME OF<br>DECEASED<br>(Type or print) | Ver                  | First              | OK. Mid   | Roll          | last                                       | 4. DATE<br>OF<br>DEATH | Month                           | h Do             | 19 J 7                                  |
| S. SEX                                 | 6. COLOR C           | R RACE 7. N        | ARRIED NEVER MA                                     | ARRIED B.     | DATE OF BIRTH                              |                        | 9. AGE (In/years last birthway) | IFUNDER TYEA     |   |
| male                                   | wh                   | ite WID            | OWED DIVO   | RCED 🙀        | 6-18-                                      | 896                    | 63 yrs.                         | Months Days      | Hours Min.                              |
| o. USUAL OCCUPA                        | TION (Give kind      | of work done       | 106. KIND OF BUSINES                                | S OR INDUSTR  | 11. BIRTHPLACE                             | (Stote or foreign      | country)                        | 12. CITIZEN      | OF WHAT COUNTRY?                        |
| aun                                    | 7 +                  | Chem               | ist   |               | ma   |                        |                                 | 11.5             | sa                                      |
| 3. FATHER'S NAME                       |                      |                    |   |               | 14. MOTHER'S MA                            | IDEN NAME              |                                 |                  |   |
| Edua                                   | De                   | Rober              | 1   | 44.69         | Bline                                      | Kels                   | uer                             |                  |   |
| 5. WAS DECEASED                        |                      | RMED FORCES?       | 16. SOCIAL SECURITY                                 | 1 NO. 17. IN  | FORMANT /                                  |                        | Address                         |                  |   |
| No                                     |                      |                    | Unknown   | 1             | ursii .                                    | Home                   | Recor                           | 20               |   |
| 18. CAUSE OF D                         | EATH [Enter only     | y one couse per    | line for (o), (b), and (                            | c).]          |  | \                      |                                 | IN               | TERVAL BETWEEN                          |
| PART I. DI                             | ATH WAS CAUS         | ED BY:<br>AUSE (a) | Cirona  | rus of        | celus                                      | in                     |                                 | /                | udden                                   |
| 420.1                                  |                      | DUE TO             |   |               | CALL ST.                                   |                        |                                 |                  |   |
| Conditions, if                         |                      | (b)                |   | f             |  |                        |                                 |                  |   |
| gove rise to imm                       |                      | DUE TO             |   |               |  |                        |                                 | 2230             |   |
| couse lost.                            |                      | (c)                |   |               |  |                        |                                 |                  |   |
| PART II. C                             | THER SIGNIFICA       | NT CONDITION       | NS CONTRIBUTING TO                                  | DEATH BUT NO  | OT RELATED TO TH                           | E TERMINAL DISEAS      | E CONDITION GIV                 | VEN IN PART 1(0) | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| PART II. C                             | ONTRIBUTING [        | 20b. DES           | SCRIBE HOW INJURY C                                 | OCCURRED. (En | nter noture of injury                      | in Port I or Port II   | of item 1B.)                    |                  |   |
| 20c. TIME OF IN.<br>Hour o. r          | n.                   |                    | 20d. INJURY OCCURRE While Not while of work of work | facto         | E OF INJURY (Hon<br>ry, street, office blo | ne, form, 20f. (Cit)   | or town)                        | (County)         | (Stote)                                 |
| 21. I certify                          | that I took          | charge of t        | he remains descr                                    | ribed abov    | e, held an A                               | utopsy [], I           | nspection .                     | Inquiry 5        | and find that                           |
| death resulte                          | ed from: No          | atural caus        | es 📆, Accident                                      | , Suic        | ide [], Hon                                |                        | ndetermined                     |                  |   |
|  | 1.                   | ^                  |   |               |  |                        |                                 |                  |   |
| ACTUAL<br>SIGNATURE                    | Trans                | 9/                 | Dunha   | nt.           | _M.D.                                      | ICAL EXAMINER          |                                 |                  | DATE SIGNED                             |
| EXAMINER'S<br>NAME (Type)              | FLAN                 | 从工                 | Brosch  | 214           |  | MEDICAL EXAMINER       | - 4                             | -2×~             | 59                                      |
| 20. 8URIAL, CREMAT                     |                      | THEREOF            | 22c. NAME OF C                                      | EMETERY OR    | CREMATORY                                  | 22d. LOCA              | TION (City, town,               | or county)       | (Stote)                                 |
| Burial                                 | 9-2                  | 7-59               |   | lle C         | emetery                                    | Rocl                   | cville,                         | Maryla           | ind                                     |
| 3. FUNERAL DIRECTO                     |                      |                    | ADDRESS<br>Dothoods                                 | Marca         |  | . REC'D BY REGIST      |                                 | STRAR'S SIGNAT   |   |
| Robert A                               | . Pumpi              | hrey,              | Bethesda,   | Mary          | rand D                                     | ATE SEP 28 'S          | a a                             | ithus I the      | atel                                    |

VS. A15ME(5) 5M 9/55

CAL EXAMINER'S CENTRICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10498

CERTIFICATE OF DEATH

10469

|   | Keg.  | DIST. NO.   |
|---|---|---|
| 1. PLACE OF DEATH O. COUNTY  MARYLAND  MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residue of STATE b. COUNTY b. | lence before admission)                                       |
| b. CITY OR TOWN (If outside careprote limits, write of c. LENGTH OF STAY IN 16 RURA) and give threst town   | c. CITY OR TOWN (If outside corporate limits, write RURAL on                            | d give rearest town)  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  | / d. STRÉET ADDRESS   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                       |
| 3. NAME OF DECEASED (Type or print) Frank 5, Ray  | Lost 4. DATE Month OF DEATH Selection   | her 2/195   |
| 5. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED  WIDOWED DIVORCED  DIVORCED  | March 14 1882 Tyrs. Manth:  | ER I YEAR IF UNDER 24 HRS. Days Hours Min.                    |
| 10a. USUAL OCCUPATION (Give kind af work dane during most of working life, even if retired)   | Clarke Co. Va.  | CITIZEN OF WHAT COUNTRY                                       |
| 13. FATHER'S NAME<br>Riddle Raystan   | 14. MOTHER'S MAIDEN NAME V. Carpel  |   |
| (Yes, no, or unknown) (If yes, give wor or dates of service) 23/-38-6/62  | This Laure Reed &   | Butanul   |
| 18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which  (b)  COVONAV | infarction ,  | INTERVAL BETWEEN ONSET AND DEATH                              |
| gave rise to immediate cause (a), stating the under- lying cause lost.  DUE TO  (c) Atterios  | clerosis-hypertension   | n 30 yr.  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT   | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN P.                               | PERFORMED?  |
| OK CONTRIBUTING (I CAUSE OF DEATH) (IF EITHER, NOTIFY MEDICAL EXAMINER)   | D. (Enter nature of injury in Port I or Port II of item 18.)                            |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 Of work of work 19 of work 19  | ACE OF INJURY (Home, form, 20f. (City or town) ctary, street, office bldg., etc.)       | (County) (State)  |
| 21. I certify that I attended the deceased from AUG alive an Sept 20, 19 5 9, and that death  ACTUAL SIGNATURE AUGUST (SIGNATURE)   | accurred at 1 A.M. fram the causes and an ADDRESS (Street, city or town, state)         | I last saw the decease<br>the date stated above<br>DATE SIGNE |
| PHYSICIAN'S FRANK L. WEAVER   | JR  |   |
| REMOVAL (Specify) 9/24/37 Fart den  | R CREMATORY (22d. LOCATION (City, town, or county                                       | (State)   |
| 13. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS,   | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S S  | Hims  |

|     | HEADEN/          |                    | 10204  |
|-----|------------------|--------------------|--|
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# TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10470

# 10499 CERTIFICATE OF DEATH

Reg. Dist. No.

| 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |
|--|---|
| county Montgomery MARYLAND   | state Maryland county Montgomery                                      |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY  | CITY (If outside corporata limits, write RURAL and give nearest town) |
| OR end give neerest town) TOWN Derwood (in this plece) TOWN | or Town Derwood   |
| HOSPITAL OR  | STREET (If rurel give location)                                       |
| INSTITUTION OR STREET ADDRESS R.F.D.   | ADDRESS R.F.D. # 1  |
| 3. NAME OF (First) (Middla)  | (Last) 4. DATE (Month) (Day) (Yeer)                                   |
| (Type of Print) Edward Lee Run1on  | OF  |
| S. SEX   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE C   |   |
| Male White Whowen, Divorcep, Specify Married Marc  | h 13 1894 65 yrs. Months Days Hours Min.                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if OR INDUSTRY                     | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT         |
| retired arm Labor Farming  | Vi mainia   |
| 13. FATHER'S NAME  | 14. MOTHERS MAIDEN NAME   |
| David Runion   | Anne Bixler   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.   | 17. INFORMANT & ADDRESS   |
| (Yas, no, or unk.) (If Yes, give wer or detes of service) Unknown  | Hazel B. Runion Same As 2   |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   | RTIFICATION INTERVAL BETWEEN  |
| n  | ONSET AND DEATH   |
| 524 X IMMEDIATE CAUSE (A) PREVMON  | 19 26 Krs.  |
| DISEASES OF CONDITIONS IF ANY IN Brock   | 4515 10 + 16-   |
| GIVING RISE TO THE ABOVE CAUSE   | 0.743.  |
| STATING UNDERLYING CAUSE LAST. DUE TO  |   |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE                                   |   |
| DISEASE OR CONDITION CAUSING DEATH. /T 127105 C/1  | erosis  |
| 198. DATE OF OPERATION 196. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? , YES NO #   |
| 21a. ACCIDENT WAS UNDERLYING   21b. PLACE (Homa, farm, factory,  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)          |
| OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., etc.)   | (State)   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While Not while                               | 21f. HOW DID INJURY OCCUR?  |
| M. et work et work   |   |
| 22. I hereby certify that I attended the deceased from Slaw 2  | 3, 1959, to Sup \$ 30, 1951, that I last saw the deceased             |
|  | 5:45AM, from the causes and on the date stated above. 9/30/59         |
| SIGNATURE 111 17   | ADDRESS (Straet, city, town, state) DATE SIGNED                       |
| James W. Zgan M.D. M.D.  | 7720W iscorrin Art. Betherla Mil                                      |
| 23. PURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR  | CREMATORY LOCATION (City flown, or county) (State)                    |
| Burial Oct. 3 59 Parklawn  | Rockville Md.   |
| 24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE   | 25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS                               |
| DATE OCT 2'59 arthur & Kings   | Royan Barber Laytonsville, Md.  |

MARYLAND STATE DEPARTMENT OF HEALTH-MALTIMORE, IS

# GOOD CERTIFICATE OF DEATH

|                                       | Comment ages is  |                                |                      |
|---------------------------------------|--|--------------------------------|----------------------|
|                                       | n Feet and   | CALIFORN                       | VT-2015 Call on the  |
|                                       | nerod off.   | Hapt of                        | - booming and        |
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| . Eliver                              |  | A                              |                      |

7. MARRIED NEVER MARRIED

None

None

Intracranial

Acute lymphocy

20e. PLA

July 8

22c. NAME OF CEMETERY OR CREMATORY

\_, and that death

fact

20b. DESCRIBE HOW INJURY OCCURRED.

Not while at work at work

**ADDRESS** 

20d. INJURY OCCURRED

S. Trier, M.D.

MARYLAND

c. LENGTH OF STAY IN 16

82 days

Middle

Wilson

DIVORCED [

Bethesda

NAME OF DECEASED

Mala

Child

13. FATHER'S NAME

No

Wilbur E. Sawyer

Conditions, if ony, which gove rise to immediate

cause (a), stating the underlying couse lost.

20c. TIME OF INJURY

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

220. BURIAL, CREMATION.

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

Hour o. m.

p. m.

200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

PART f. DEATH WAS CAUSED BY:

S. SEX

(Type or print)

d. NAME OF HOSPITAL (If not in hospitaf, give street address)
OR INSTITUTION

6. COLOR OR RACE

White

The Clinical Center. Bethesda ll. Md.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO

IMMEDIATE CAUSE (o)

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

DUE TO

DUE TO

Day, Year

21. I certify that I attended the deceased from September 28 10 59

Jerry

22b. DATE THEREOF

PART IF. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT Meckel's diverticulum

First

Stephen

WIDOWED [

| IE OF DEATE                               |                |                      | Reg. Dis   | t. No.   |           |                   |
|---|----------------|----------------------|------------|----------|-----------|-------------------|
| 2. USUAL RESIDENCE (Who of STATE Virginia | ere deceased   | b. COUNTY<br>Henri   |            | e befo   | re admis  | sion)             |
| c. CITY OR TOWN (If o                     | utside corpore | ote limits, write RI | JRAL and g | ive nec  | arest fow | n)                |
| Richmond                                  |                | 83>                  | ( - 3      |          |           |                   |
| d. STREET ADDRESS                         |                | 001                  |            |          | e. IS RE  | SIDENCE           |
| 411 Lakewo                                | od Dri         | ve                   |            |          |           | A FARM?           |
| Lost                                      | 4. DATE<br>OF  | Mon                  | h          | Do       | у         | Year              |
| Sawyer                                    | DEATH          | Septen               | her        | 28       | 3.        | 1959              |
| . DATE OF BIRTH                           | 5              |                      |            |          |           | ER 24 HRS.        |
| November 26                               | 1951           | 7 yrs.               | Months     | Doys     | Hours     | Min.              |
| TRY 11. BIRTHPLACE (Stote                 |                |                      | 12. CIT    | ZEN C    | F WHA     | T COUNTRY         |
| Virgi                                     | -4-            |                      |            |          |           |                   |
| 14. MOTHER'S MAIDEN N                     |                |                      |            | U.       | S. 1      | 1.                |
|   |                |                      |            |          |           |                   |
|   | Hudson         |                      |            |          |           |                   |
| FORMANT The Cli                           | nical          | Center*d*            | fëdica     | 1 R      | ecor      | rd                |
| Bethesd                                   | alli.          | Maryland             |            |          |           |                   |
|   |                |                      |            |          |           | ETWEEN            |
| emorrhage                                 |                |                      |            | ONS      | day       | DEATH             |
| iomot i mage                              |                |                      |            | -        | ua        | 0                 |
|   |                |                      |            |          | -1        | 3537              |
| rtic leukemia                             |                |                      |            |          | 14        | mos.              |
|   |                |                      |            |          |           |                   |
|   |                |                      |            |          |           |                   |
| NOT RELATED TO THE TERMI                  | NAL DISEASE    | CONDITION GIV        | EN IN PART | 1(0)     | 9. WAS    | AUTOPSY<br>ORMED? |
|   |                |                      |            |          |           | NO                |
| (Enter nature of injury in P              | ort I or Port  | II of item 1B.)      |            |          |           |                   |
|   |                |                      |            |          |           |                   |
| CE OF INJURY (Home, form,                 | 20f. (City )   | or town)             | 10         | ounty)   |           | (Stote)           |
| ary, street, office bldg., etc.           | )              |                      | ,          | .0011177 |           | (3,016)           |
|   |                |                      |            |          |           |                   |
| , 19 59, to Se                            | ptembe         | r 2819 59            | that I I   | ast so   | w the     | deceased          |
| occurred of 2:30                          | M. from        | the causes o         | nd on th   | e da     | te stat   | ed above          |
|   | ADDRESS (Stre  | et, city or town,    | itate)     |          |           | ATE SIGNED        |
| The Cl                                    |                | Center               |            |          | 9-2       | 8-59              |
|   |                | titutes              | of Ho      | 97+      |           |                   |
|   |                |                      |            | ar.      | II.       |                   |
| Detnes                                    | as TT          | Marylan              | Q          |          |           |                   |

22d. LOCATION (City, town, or county)

24b. REGISTRAR'S SIGNATURE

Colling & House

240 REC'D BY REGISTRAR

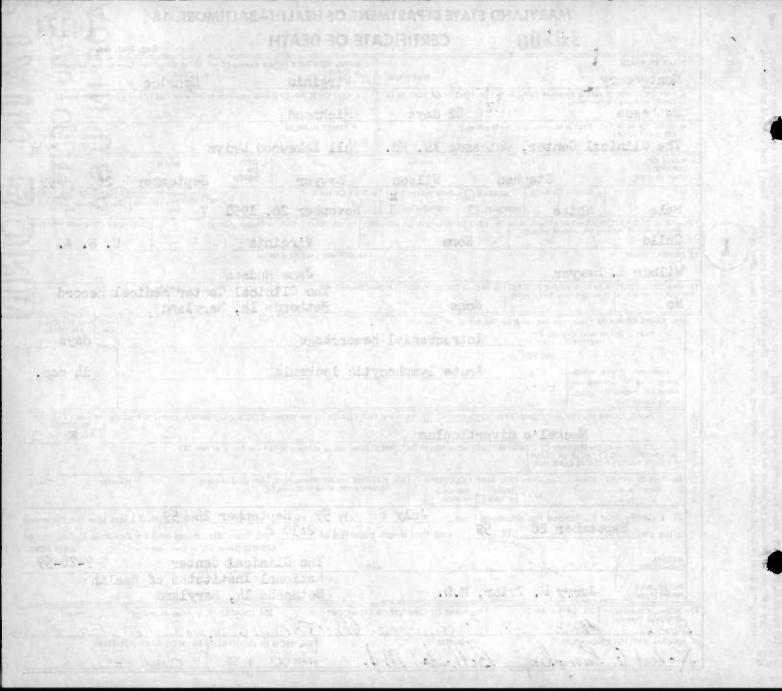
'59

DATE OCT

I director, filed with erol shauld þ puo .5 filled papers. puo mave attending TO FUNERAL DI

death. Page

VS A15 (4) 15M 10/57



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

TO HOSPITAL OR

VS A15 (4) 15M 10/57

death: Page 4

| is to burial, cremation, or remayal, and in any event within 72 hours after death. | )  |                       |
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| emaval,  | 2  | MEDICAL CERTIFICATION |
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| or to burial, crematian, ar remaval, and in any event within 72 hours after death. |    | MEDICAL               |
| urial, ci  |    |                       |
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|  | MARY   | LAND           | STATE DEPA                              | RTME                    | NT OF HEALTI   | H-BAL                                      | TIMORE, 1                         | 8                       | 1 ()       | 170                     |
|--|--|----------------|---|-------------------------|--|--|-----------------------------------|-------------------------|------------|-------------------------|
| E Maria  |  | 050            | CERTI                                   | FICA                    | TE OF DEATI  | Н  |                                   | Reg. Dist. No           | -          | 472                     |
| L PLACE OF DE  | and the same of th |                | MARY                                    | LAND                    | 2. USUAL RESIDENCE (W. o. STATE Virgin                     | here decease                               | d lived. If institution b. COUNTY | Residence before Fairfa |            | ion)                    |
| b. CITY OR TO  | OWN (If outside corporate limit give nearest town)   |                | c. LENGTH OF STAY                       | IN 1b                   | c. CITY OR TOWN (IF  | outside corpo                              | prote limits, write RU            | RAL ond give ne         | arest town | )                       |
| Bethes   |  |                | 64 days                                 |                         | Falls Chur   | ch   | 8                                 | 3x-3                    |            |                         |
| d. NAME OF<br>OR INSTITU   | HOSPITAL (If not in hospital, g  | ive street o   | ddress)                                 |                         | d. STREET ADDRESS  |  |                                   |                         | e. IS RES  | IDENCE<br>FARM?         |
|  | inical Center.   | Beth           | esda 14, M                              | id.                     | 124 West M   | [arsha]                                    | Ll Street                         |                         |            | NO.                     |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                    | ) Bovd   | st             | Middle<br>Frankl                        | in                      | lost<br>Schaff   | 4. DATE<br>OF<br>DEATH                     | Septembe                          |                         |            | Year<br>19 59           |
| 5. SEX   |  | 7. MARRI       | ED NEVER MARRIE                         |                         | DATE OF BIRTH  |  | 9. AGE (In years                  | IF UNDER 1 YEAR         |            |                         |
| Male   | White  | WIDOWE         |   |                         | November 5.  | 1909                                       | ost birthdoy)                     | Months Doys             | Hours      | Min.                    |
| IOa. USUAL OCC   | UPATION (Give kind of work   | done 10b.      | IND OF BUSINESS O                       |                         |  | or foreign c                               |                                   | 12. CITIZEN C           | OF WHAT    | COUNTRY?                |
| Account  | of working life, even if retired   |                | overnment                               |                         | North Car  | olina                                      |                                   | U                       | . S.       | A.                      |
| 3. FATHER'S NA   | ME   |                |   |                         | 14. MOTHER'S MAIDEN  | NAME                                       |                                   |                         |            |                         |
| Noah I   | . Schaff   |                |   |                         | Margaret   | Farav                                      | ee                                |                         |            |                         |
| 5. WAS DECEAS  | SED EVER IN U. S. ARMED FOR  |                | OCIAL SECURITY NO                       |                         | FORMANT The Med  |  |                                   |                         |            |                         |
| No   |  |                | None                                    | Th                      | e Clinical C   | enter                                      | , Bethesda                        | a 14, Ma                | ryla       | nd                      |
| PART  134  Condition gove rise couse (o), s lying cous                       | 10   | Sh<br>Cr<br>My | ock (Clini<br>yptococcos<br>reloid Meta | ical)<br>sis (<br>aplas | lungs & brai   | ytope                                      |                                   | 3                       | mos.       | 35 min                  |
| PART   | II. OTHER SIGNIFICANT CON  |                |   |                         |  | INAL DISEAS                                | E CONDITION GIVE                  | N IN PART 1(0)          | 19. WAS A  | RMED?                   |
|  |  |                |   |                         | e, jaundice  |  |                                   |                         | YES 🔼      | NO 🗌                    |
| OR CONTRIB   | ENT WAS UNDERLYING DENTH WAS UNDERLYING CAUSE OF DEATH MOTIFY MEDICAL EXAMINER)  | ZUB. DESC      | KIBE HOW INJURY OF                      | CCURRED.                | (Enter noture of injury in                                 | Port I or Por                              | f II of item IB.)                 |                         |            |                         |
| 20c. TIME OF<br>Hour   |  | While          | JURY OCCURRED Not while of work         | 20e. PLAC<br>focto      | DE OF INJURY (Home, form<br>ory, street, office bldg., etc | n, 20f. (Cit)                              | y or town)                        | (County)                |            | (Stote)                 |
| alive an_ ACTUAL SIGNATURE PHYSICIAN' NAME (Type  120. BURIAL, CRE EMOVAL (S | MATION, 22b. DATE THEREC   | Andri          | ole, M. D.                              | Meath (                 | D. The Clir<br>National<br>Bethesda                        | AM, from ADDRESS (Spical Linst Linst Linst | treet, city or town, s            | nd on the do            | ite state  | ed abave.<br>ATE SIGNED |
| Buned  | l Sept 10, 1   | 957            | nalima                                  | Men                     | noved Park   | Fre  | fay a                             | untig                   | la         |                         |
| 3. FUNERAL DIR   | ECTOR'S SIGNATURE  | 0              | ADDRESS                                 | 1                       | 24a. REC'  | D BY REGIST                                | TRAR 24b. REGIST                  | RAR'S SIGNATU           | RE         |                         |
| · C. O.  | Idea mos   | 2 les          | anglia                                  | 16                      | DATE   | PED 1.1                                    | 150                               | -0 0 L                  | ,          |                         |

Locald Cinternal Land office the Contern Special Lie, Id. 47.45 Hone there of the Charles I have been any . BOU ! allystations of the altification stories. Physical , meanwhord hairs road, founded - 1 co materials as as a community of the track of materials and the community of Bernauson Di, Lorykenn A THOUSAND TO THOUSE A STATE OF THE PARTY OF THE PAR

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4 should be crer.otion, Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) Service of the last o. COUNTY a. STATE b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURA c. LENGTH OF STAY IN 1b . IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? YES NO 1 NAME/OF Middle 4. DATE Month Day Year OF DECEASED (Type or print) 19 9. AGE (In More lost birthday) IF UNDER TYPAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Min. Months Days Hours retained WIDOWED R DIVORCED | 10d USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) pe 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME may 50 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Address (If yes, give war or dates of service) Give INTERVAL BETWEEN 18. CAUSE OF DEATH | Enter only one cause per line for (o), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise ta immediate cause DUE TO (a), stating the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 00 PERFORMED? 0 Ö YES 🗍 NO Z 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) pe PRIMARY OF CONTRIBUTING CAUSE OF DEATH. should 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) edical factory, street, office bldg., etc.) While q. m. Not while at work of work p. m. 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection X, Inquiry , and find that death resulted from: Natural causes 174 Accident | Suicide . Undetermined cause Homicide . Ch: CTO e) DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER forwarded to FUNERAL ASSISTANT MEDICAL EXAMINER **EXAMINER'S** cute the DEPUTY MEDICAL EXAMINER NAME (Type)

22c. NAME OF GEMETERY OR CREMATORY

ADDRE65

22d IQCATION (City, town, or county)

24b. REGISTRAR'S SIGNATURE

Ciriling of thous

24a. REC'D BY REGISTRAR

SEP 3 0 '59

(State)

VS. A15ME(5) 5M 9/55

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22a. BURIAL, CREMATION,

REMOVAL (Specify)

23 FUNERAL DIRECTOR'S SIGNATURE

**EXAMINER: This** 

MEDICAL

DEPUTY

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|  |  |             | TO STANDARD OF MEDICAL |
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TO HOSPITAL OF

VS A15 (4) 15M 9/5B

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CEPTIFICATE OF DEATH

10474

| Reg. Dist. No.  |                            |                                     |                       |                       |                    |                    |
|---|----------------------------|-------------------------------------|-----------------------|-----------------------|--------------------|--------------------|
| 1. PLACE OF DEATH o. COUNTY   |                            | 2. USUAL RESIDENCE (Whe             |                       |                       | ence befare admis  | ssian)             |
| MONTGOMERY  | MARYLAND                   | o. STATE                            | Ь                     | . COUNTY              | JTK                |                    |
|   | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (If ou              | utside corporate lim  | nits write RURAL one  | d give negrest tow | orb)               |
| RURAL and give nearest town)  | 12 /                       | 1/1 -                               |                       | nis, witho konta one  | give wooden in     | ,                  |
| 1 QKOMA / Ank   | 16 days                    | Takom                               | 4 / A-RI              | <u> </u>              |                    |                    |
| <ul> <li>NAME OF HOSPITAL (If not in hospital, give street or<br/>OR INSTITUTION</li> </ul> | ddress) /                  | d. STREET ADDRESS                   |                       |                       | e. IS RE           | SIDENCE<br>A FARM? |
| WashINGTON SOLNITAR   | Clum + Hosp.               | 7809 GA                             | LRIAND                | 100                   |                    | NO                 |
| 3. NAME OF First  | Middle                     | Last                                | 4. DATE               | Month                 | Day                | Year               |
| (Type or print)   | Ellen                      | - Shaffap                           | OF<br>DEATH           | SOOT                  | 16                 | 19.59              |
| 5. SEX   6. COLOR OR RACE   7. MARRIE   | ED MEVER MARRIED           | B. DATE OF BIRTH                    | 9. AGE                |                       | ER 1 YEAR IF UND   |                    |
| Female White WIDOWE   |                            | 11-12-11                            |                       | birthday) Months      | Days Haurs         | Min.               |
| 10a. USUAL OCCUPATION (Give kind af work done during most af warking life, even if retired) | IND OF BUSINESS OR INDU    | ISTRY 11. BIRTHPLACE (Stote o       | r foreign country)    | 12. CI                | ITIZEN OF WHAT     | COUNTRY            |
| Housewife   |                            | PENNA                               | ,                     |                       | 115.               |                    |
| 13. FATHER'S NAME   |                            | 14. MOTHER'S MAIDEN NA              |                       |                       | 14.                |                    |
| John L. Zimmerma  | 2 ~                        | ANNIE                               | L. 1                  | PedaN                 |                    |                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. S  | OCIAL SECURITY NO.         | INFORMANT                           |                       | Address               |                    |                    |
| 1/2)  |                            | HOSPITA.                            | 1 Re                  | coods                 |                    |                    |
| 18. CAUSE OF DEATH [Enter only one couse per line   | e for (o), (b), and (c), ] |                                     |                       |                       | INTERVAL B         | ETWEEN             |
| PART I. DEATH WAS CAUSED BY:  |                            |                                     |                       |                       | ONSET AND          | DEATH              |
| IMMEDIATE CAUSE (o)   | nanilion                   |                                     |                       |                       | 3 m                | inna:              |
| 104 X DUE TO  |                            | 1                                   |                       |                       | 1 m                | Atma               |
| Canditians, if any, which (b)   | Iver In                    | lurp                                |                       |                       | 6 1110             | 7111               |
| gove rise to immediate couse (a), stoting the under-  |                            | 0 0 1                               | - 44                  | 1 1 .                 | 10                 |                    |
| lying cause lost.   | rcinoma                    | of Keclum                           | c Mel                 | 2136126               | 1-21               | y ears             |
| PART II. OTHER SIGNIFICANT CONDITIONS CO  | ONTRIBUTING TO DEATH BUT   | NOT RELATED TO THE TERMIN           | AL DISEASE CONT       | DITION GIVEN IN PA    | ART 1(a) 19. WAS   | AUTOPSY            |
| PART II. OTHER SIGNIFICANT CONDITIONS CO  |                            |                                     |                       |                       |                    | ORMED?             |
|   | RIBE HOW INJURY OCCURRE    | ED. (Enter noture of injury in Po   | ort I or Port II of i | tem 18.)              |                    |                    |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                         |                            |                                     |                       |                       |                    |                    |
| 20c. TIME OF INJURY Month, Day, Year 20d. IN.   |                            | ACE OF INJURY (Home, farm,          |                       | rn)                   | (County)           | (State)            |
| 20c. TIME OF INJURY Month, Day, Year 20d. IN. Hour o. m. p. m. 19 While at work             | IAOI WIIIE                 | octory, street, office bldg., etc.) |                       |                       |                    |                    |
|   | 0                          | f ro. C                             | 1 1/                  |                       |                    |                    |
| 21. I certify that I attended the decease   |                            | 5_, 19.5_7, to                      | 110-16                | _, 19_27,that I       | last saw the o     | deceased           |
| alive of 15 195   | , and that death           | - /L                                |                       | auses and an th       | he date state      | d abave            |
| 1 1 80 1 VP   | 7 1                        | , MA                                | DDRESS (Street, cit   | ty ar town, stote)    | DA                 | TE SIGNET          |
| SIGNATURE WELL WES WOOD   | esman                      | M.D. Taking                         | rock.                 | IM                    | 91                 | 16/5               |
| PHYSICIAN'S 14/ 16 -11  | . =7 1                     | el                                  |                       |                       |                    | , ,                |
| NAME (Type) WILLYCO   | V Easim                    | 1011                                | 7                     |                       |                    |                    |
| 220. BURIAL, CREMATION, 226 DATE THEREOF  | 22c. NAME OF CEMETERY      | OR CREMATORY                        | 22d DOCATION (C       | City, town, ar county | ) (Sto             | ote)               |
| 120/59 130 19   | Bun anio                   | n Clinelly                          | 1selly 6              | ne R.1)               | Pens               | CA                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS 1 2 1 12           | 230. REC'D                          | BY REGISTAR           | 24b. REGISTRAR'S      | SIGNATURE          |                    |
| J'union Walurs, 254 C   | arrall 12 NOV. K           | SELL HC DATSEP                      | 1 7 '59               | arthur &              | thank              |                    |
| 11  |                            |                                     |                       |                       |                    |                    |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. COUNTY o. STATE b. COUNTY ontgomery MARYLAND Montgomerv CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nd give nearest town) Bethesda DOA Glen Echo Heights d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Suburban Hospital 5305 Tusearawas Rd YES NO NAME OF DECEASED First Middle 4. DATE Day Year OF DEATH Lacotha (Type or print) Shannon Sept. 30 1959 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH IF UNDER TYPAR IF UNDER 24 HRS. last birthday) Min. Hours hite Female WIDOWED | DIVORCED | 1887 yrs. 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housewife Own Home Mt. Erie. Ill. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Robert O. Miller Nellie Camp 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Item #2 No Hus band None 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause **DUE TO** (o), stoting the underlying couse lost. PART II. QTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO Z 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) Not while n.m. p. m. at work at work 21. I certify that I taak charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes . Accident , Suicide , Homicide , Undetermined cause . DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER EXAMINER'S 9-30-59 DEPUTY MEDICAL EXAMINER 134 NAME (Type) 220. BURIAL CREMATION, 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) Rockville, Maryland Parklawn Cemetery **ADDRESS** 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR DATE OCT 5 2 '59 Robert A. Pumphrey, Bethesda, Maryland arihun & Kame

VS. A15ME(5) 5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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e. IS RESIDENCE

ON A FARM?

Year

195

YES NO

IF UNDER 1 YEAR IF UNDER 24 HRS

Hours

INTERVAL BETWEEN

PERFORMED?

12. CITIZEN OF WHAT COUNTRY?

115A-

Days

Reg. Dist. No

Months

YES NO 1 (Stote) (County) 1937, that I last saw the deceased and that death accurred at AM, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) 615 W.Montg.Ave..Rockvil William S. Murphy NAME (Type) 22d. LOCATION (City, town, or county) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) Rockville Cemetery 9-12-59 Rockville, Maryland Burial 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 24a. REC'D BY REGISTRAR Robert A. Pumphrey, Bethesda, Maryland SEP 1 1 '59 Orihun & Kraus

VS A15 (4) 15M 9/5B

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Robert v. Perdirey, Pathwale, Maryland on the St. 1 of the Maryland

arthur & House

ATTENDING PHYSICIAN: The law requires that the deoth certificote be executed within 24 hau, by the haspital or attending physician.

CTOR: After this certificate hos been signed by the attending physician and campletely filled in by a detached far use as the burial-transit permit. Then please remave carbon papers. Poges 1 and 2 is to burial, crematian, ar remaval, and in any event within 72 haurs after death. TO HOSPITAL OR A May be retained by TO FUNERAL LACET page 3 should be dithe registror prior to

| MARYLAND   | STATE D      |
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| DUNTY flontgomery  | ,            |
| TY OR TOWN (If outside corporate limits, write JRAL and give nearest tawn)         | c. LENGTH OF |
| AME OF HOSPITAL (If not in hospital, give street of RINSTITUTION Washington Santas |              |
| ASED First Grace   | Ma           |
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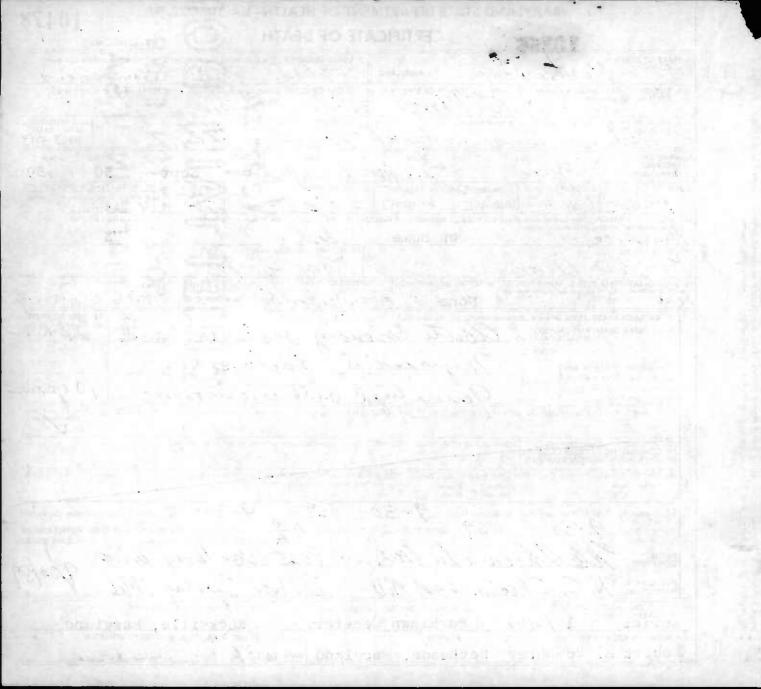
Robert A. Pumphrey

RTIFICATE OF DEATH Reg. Dist. No.

| PLACE OF DEATH   | ALC: DECEMBER  |  |                                  | lence befare admission)               |
|--|--|--|----------------------------------|---------------------------------------|
| 10011gomery  | MARYLAND   | a. STATE Md.                           | b. COUNTY Flow                   | etgenery                              |
| b. CITY OR TOWN (If outside corporate limits, write  | c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (If outside of         | corporate limits, write RURAL-an | d/give nearest town)                  |
| Takoma fark  | lhis.  | 5651/Vel Sp.                           | 1274                             |                                       |
|  | ddress)  | d. STREET ADDRESS.                     | 1/2                              | e. IS RESIDENCE                       |
| Washington Sanitadia   | en + Hopetal   | 733 3/190                              | ave.                             | YES NO                                |
| NAME OF First  | Middle   |  |                                  | Day Year                              |
| (Type or print)  | Mand.  |  |                                  | 30 1959                               |
| SEX 6. COLOR OR RACE 7. MARRII   | ED NEVER MARRIED   | 8. DATE OF BIRTH                       |                                  | · · · · · · · · · · · · · · · · · · · |
| fremale White WIDOWEL  | DIVORCED [   | 8-6-85                                 | 76 yrs. /                        | 24 Haurs Min.                         |
| Da. USUAL OCCUPATION (Give kind of wark dane 10b. K  | IND OF BUSINESS OR INDU  | STRY 11. BIRTHPLACE (State ar forei    | ign country) 12.C                | ITIZEN OF WHAT COUNTRY?               |
|  | Own Home   | 12.6.                                  |                                  | US                                    |
| A. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME               | WILLIAMS                         |                                       |
| Marcellus Donn   |  | Mary Bro                               | 995                              |                                       |
|  | OCIAL SECURITY NO.   | NFORMANT                               | Address                          | ( , 1 , D                             |
|  | None Wa  | Shington Sand                          | Las him + HE                     | spital Kecong                         |
| D. COUNTY  MARYLAND  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (If outside corporate limits, write RURAL |  |  |                                  |                                       |
| PART I. DEATH WAS CAUSED BY:   | OWN Home  14. MOTHER'S MAIDEN NAME  DECEASED EVER IN U. S. ARMED FORCES? Unknown)  DECEASED EVER IN U. S. ARMED FORCES? None  CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Inditions, if any, which we rise to immediate se (a), stoting the under- g cause lost.  OWN Home  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  15. MOTHER'S MAIDEN NAME  16. SOCIAL SECURITY NO.  INFORMANT  Address  NOTE TO SECURITY NO.  INTERVAL BETWEEN ONSELAND DEATH  ONSELAND DEATH  OUT TO  Generalized auteruscellion  (b)  DUE TO  Generalized auteruscellion  (c)  Generalized auteruscellion  (d)  US  16. MOTHER'S MAIDEN NAME   |  |                                  |                                       |
| 11/7-1   | CW -C U  | many occur                             | orno aco                         |                                       |
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| gave rise to immediate   | regociación  | and free see                           |                                  | /                                     |
| couse (a), storing the under-  | The line   | 1 Galorena                             | Peroi-1-                         | 10 years                              |
| 101  | euro   | a union                                |                                  | ADT IV AND AWAS AUTODOX               |
| PART II. OTHER SIGNIFICANT CONDITIONS  | DNIKIBUTING TO DEATHOBUT   | NOT RELATED TO THE TERMINAL DIS        | SEASE CONDITION GIVEN IN P       | PERFORMED?                            |
|  |  |  |                                  | YES NO                                |
| 20a. ACCIDENT WAS UNDERLYING 20b. DESCI  | RIBE HOW INJURY OCCURRE  | D. (Enter nature of injury in Part I o | r Port II af item 18.)           |                                       |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                                  |                                       |
|  | - for  |  | (City ar tawn)                   | (County) (State)                      |
| 10   | HACH WHITE   | story, street, drive blug., etc.)      |                                  |                                       |
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|  | aker. M.D  | . S,'  ver                             | Spring, M                        | A hook                                |
|  | 22c. NAME OF CEMETERY O  | R CREMATORY 22d. L                     | OCATION (City, town, ar county   | r) (Stote)                            |
|  | Parklawn C   | emetery F                              | Rockville, Ma                    | rvland                                |
| B. FUNERAL DIRECTOR'S SIGNATURE  |  |  |                                  |                                       |

Bethesda, Maryland DATE OCT 2 '59

VS A15 (4) 15M 9/5B



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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| 1 | 10500                       | S CERTIFIC       | ATE OF DEATH   | R    |
| , | 1. PLACE OF DEATH a. COUNTY | MARVIAND         | 2. USUAL RESIDENCE (Where deceased lived. If into g. STATE, b. COL |      |

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|                                     | 1040                                     |
|-------------------------------------|--|
| OF DEATH                            | Reg. Dist. No. 215                       |
| AL RESIDENCE (Where deceased lived. | If institution: Residence before admissi |

|         | Montgomery  | MARYLAND                     | District                         |                        | lumbia                              | m: Kesidenc | e belore   | V                                    |
|---------|---|------------------------------|----------------------------------|------------------------|-------------------------------------|-------------|------------|--------------------------------------|
| 1       | b. CITY OR TOWN (If outside carporate limits, write           | c. LENGTH OF STAY IN 1b      | c. CITY OR TOWN (If              |                        |                                     | JRAL ond g  | ive neares | st town)                             |
| 4       | RURAL and give nearest town) Bethesda (Rural)                 | 60 days                      | Washingto                        |                        | 110                                 | 7 4 .       | 3          |                                      |
| 1       | d. NAME OF HOSPITAL (If not in hospital, give stre            |                              | d. STREET ADDRESS                | /4.5                   |                                     | A           |            | IS RESIDENCE                         |
|         | U. S. Naval Hospita.  |                              | 1645 Trin                        | nidad                  | Ave., S                             | S.E.        |            | ON A FARM?                           |
| 3       | NAME OF First DECEASED (Type or print) Harry                  | Middle                       | SINGLETON                        | 4. DATE<br>OF<br>DEATH | Septe                               |             | Doy        | Year 5 19 59                         |
| 5       |   |                              | B. DATE OF BIRTH                 |                        |                                     | IF UNDER    |            | UNDER 24 HRS.                        |
|         |   | WED DIVORCED                 | 4-6-10                           |                        | 49 yrs.                             | Manths      | Doys H     | daurs Min.                           |
| -       | 0o. USUAL OCCUPATION (Give kind of work done 10               | b. KIND OF BUSINESS OR INDU  | STRY 11. BIRTHPLACE (Stote       | ar fareign co          | untry)                              | 12. CITIZ   | ZEN OF W   | HAT COUNTRY?                         |
| X       | during most of working life, even if retired)  Baker          |                              | So. Car                          | colina                 |                                     | II          | S.A.       |                                      |
| 1       | 3. FATHER'S NAME  |                              | 14. MOTHER'S MAIDEN              |                        | 10 10 10 10                         |             | W-111      |                                      |
|         | Wade SINGLETON  |                              | Agnes MC                         | BRIDE                  | 5                                   |             |            |                                      |
| ī       | 5. WAS DECEASED EVER IN U. S. ARMED FORCES?                   | 6. SOCIAL SECURITY NO.       | NFORMANT                         | 10114101               |                                     | ess sam     | e as       | 3 #2                                 |
| 1       | Yes, no, or unknown) (If yes, give wor or dates of service)   | (W                           | ) Mrs. Cath                      | erine                  | L. Sir                              |             |            | "                                    |
| -       | 18. CAUSE OF DEATH [Enter only one couse per                  | line for (a), (b), and (c).] |                                  |                        |                                     | -0          | INTERV     | AL BETWEEN                           |
|         | PART I. DEATH WAS CAUSED BY:                                  | conchogenic c                | arcinoma wi                      | th me                  | tastase                             | g           | ONSET      | AND DEATH                            |
|         | IMMEDIATE CAUSE (a) DUE TO                                    | · ononogonizo                | ar official wi                   | OII MC                 | oab oabc                            |             | 1          |                                      |
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| H       | lying couse lost.   |                              |                                  |                        |                                     |             |            |                                      |
| TATION. | PART II. OTHER SIGNIFICANT CONDITION                          | S CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERM          | INAL DISEASE           | CONDITION GIV                       | EN IN PART  |            | WAS AUTOPSY<br>PERFORMED?<br>ES X NO |
| Crown   |   | ESCRIBE HOW INJURY OCCURRED  | D. (Enter nature of injury in    | Port I or Port         | II of item 1B.)                     | 1,3         |            |                                      |
| 1       | 20c. TIME OF INJURY Month, Doy, Year 20d                      | . INJURY OCCURRED 20e. PL    | ACE OF INJURY (Home, farm        | n, 20f. (City          | or town)                            | (C          | ounty)     | (Stote)                              |
| 1401014 | Hour a.m. Whi   | le Not while for             | ctory, street, office bldg., etc | s.)                    | -15                                 |             |            |                                      |
| 1       | 21. I certify that I attended the dece                        |                              | 10 50 45 9                       | Sont                   | 15 150                              |             |            |                                      |
|         |   |                              |                                  |                        |                                     |             |            |                                      |
| 1       | alive an Sept. 14 , 19  | .59, and that death          |                                  |                        | he causes and<br>eet, city or town, |             | date si    | DATE SIGNED                          |
|         | ACTUAL DOME OF VI   | 1551                         |                                  |                        |                                     | ,           | 0          | 1E EO                                |
|         | SIGNATURE   | -10.7                        | M.D. U. S. N                     | vavar                  | HOSDICS                             | £.L         | 9-         | -12-29                               |
|         | PHYSICIAN'S Douglas R. F                                      | COTH, LCDR, MC               | , USNBethesd                     | la, Ma                 | ryland                              |             |            |                                      |
| 2       | 20. BURIAL, CREMATION, 22b. DATE THEREOF<br>REMOVAL (Specify) | 22c. NAME OF CEMETERY O      |                                  | 22d. LOCAT             | ON (City, town, o                   | or county)  |            | (State)                              |
|         | Burial 9-18-59  | Arlington 1                  |                                  |                        | ington                              | 1           | Virg       | inia                                 |
| 2       | 3. FUNERAL DIRECTOR'S SIGNATURE /2                            | ADDRESS                      |                                  | D BY REGISTE           | AR 24b. REGIS                       | TRAR'S SIG  | NATURE     |                                      |
| 6       | J.T.RHINES & CO., 3001  | 12th ST., NE                 | WashDC DEEP                      | 1 8 '59                | acth                                | 2 th        |            |                                      |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10500 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|               |  | UJUO   | Item         |           | FilmG24        | 8             | 3-21-59                          | et                        |                        |            |                | Reg. I     | Dist. No    | •         |            |
|---------------|--|--|--------------|-----------|----------------|---------------|----------------------------------|---------------------------|------------------------|------------|----------------|------------|-------------|-----------|------------|
|               | PLACE OF DEATH<br>6. COUNTY  | Montgomery   |              |           | MARYL          | AND           | 2. USUAL RES                     |                           |                        |            | If institu     |            | dence bef   | ore admi  | ssion)     |
| -             | and give negrest town  | n)   | RURAL        |           | GTH OF STAY IN | 1 1b          |                                  |                           |                        | porote lin | nits, write    |            |             | earest to | wn)        |
|               | d. NAME OF HOSPIT  | TAL OR INSTITUTION (I  |              | ital, giv |                |               | d. STREET                        | ADDRESS                   |                        |            |                | V () 1-    | ings.       | ON        | A FARM?    |
| 3,            | Ja. Ave. I.  | lear puritue   | guon A       | ve        |                |               | 6103                             | rail                      | · Oak                  | Ave        |                |            |             | YES [     | NO 1       |
|               | DECEASED   | Carl   |              | Lee       | Middle<br>Sm   | oot           |                                  |                           | 4. DATE<br>OF<br>DEATH |            |                | 14.        | Day<br>1959 |           |            |
| 5. :          | SEX  | 6. COLOR OR RACE   | 7. MARRIEI   | D KI N    | EVER MARRIED   | 1 8.          | DATE OF BIRTH                    | 1                         | 920                    | 9. AGE     | (In years      | IFUNDE     | R TYEAR     | IF UND    | ER 24 HRS. |
|               | male   | white  | WIDOWED      |           | DIVORCED [     | ]             | April 1                          | 3, 19                     |                        | 39         | thdoy)<br>yrs. | Months     | Days        | Hours     | Min.       |
| 100           | during most of working truck of  | ON (Give kind of wark on the control of the control | lone 10b. Ki | ND OF     | BUSINESS OR IN | IDUSTI        | 11. BIRTHPL                      | ACE (Stote                | or foreign             | country)   |                |            |             | WHAT      | COUNTRY?   |
| 13.           | AME OF CCTASED EVER IN U. S. ARMED FORCES? Id. SOCIAL SECURITY NO. IP. AND DECLARS DESCRIBE HOW INJURY OCCURRED. (6), John Individually of Course of immediate course for immediate course for, which gove rise to immediate course (c), John Individually of Course of Individual Course of immediate course (c), John Individual Course of Individual C |  |              |           |                |               |                                  |                           |                        |            |                |            |             |           |            |
|               |  |  |              |           | He had         |               | Del                              | la Bl                     | У.                     |            |                |            |             |           |            |
| 15.<br>(Yes   | i. no gr unknown)  | ER IN U. S. ARMED FOI<br>(If yes, give war or dates of   | RCES? 16. S  | OCIAL S   | 18-1858        |               |                                  | oot                       | 6103                   | Fair       |                | Ave.       |             |           |            |
|               |  | TH WAS CAUSED BY:  |              |           |                | arc           | tion                             |                           |                        |            |                |            | INTER       | T AND DE  | EN<br>ATH  |
|               |  |  | Coro         | nary      | occlus         | ion           |                                  |                           |                        | 2          |                | 4.6)       |             | sudd      | en         |
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| Z             | PART II. OTI   | HER SIGNIFICANT CON  | DITIONS COL  | NTRIBUT   | ING TO DEATH   | BUT N         | OT RELATED TO                    | THE TERM                  | INALDISEAS             | E CONDI    | TION GIV       | EN IN PA   | RT 1(o) 15  | . WAS     | AUTOPSY    |
| CATIC         | Collapse   |  |              |           |                |               |                                  |                           |                        |            |                |            |             | _         |            |
| CERTIFICATION | PRIMARY Or CO  | NIKIBUTING LI 1  |              |           |                |               |                                  | jury in Por               | t I or Port II         | of item    | IB.)           |            |             |           |            |
| MEDICAL       | 20c. TIME OF INJU<br>Hour o. m.<br>p. m.   | RY Month, Day, Yea   | While        | _ N       | ot while       | PLAC<br>facto | E OF INJURY (Fry, street, office | tome, form<br>bldg., etc. | 20f. (Cit              | y or town  |                | (Co        | ounty)      |           | (Stote)    |
|               | 21. I certify the  | hat I took charge  | of the re    | emains    | described      | abov          | e, held an                       | Autops                    | у [Х], І               | nspecti    | on 🔲,          | Inqui      | ry 🗍        | and       | find that  |
|               | death resulted   | from: Natural  | auses K      | ], Ac     | cident [],     | Suic          | ide 🔲, H                         | omicide                   | □, U                   | ndeterr    | nined c        | ause [     | ].          |           |            |
|               | ACTUAL<br>SIGNATURE  | Trus 9   | B            | ציות      | - hand         | 2             | _M.D. CHIEF M                    | NEDICAL EX                | (AMINER [              | ]          |                |            |             | DATE S    | IGNED      |
|               | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street oddress)  Ga. Ave. near Burlington Ave    Carl   Lee   |  |              |           |                |               |                                  |                           |                        |            |                |            |             |           |            |
| 220           | BURIAL, CREMATIC   | N. 226. DATE THEREO  | F 2          | 10        | 1              | 1 0           | 1 17                             | 1                         | 22d. LOCA              | TION (CI   | ly, town,      | or county) | 04 /        | (Stot     | -)         |
|               | Burial   | 19-17-59   | 7            |           |                | 2/1           | lem. Pa                          | -                         | 1                      | Balt       |                |            | Ild.        |           |            |
| 23.           | FUNERAL DIRECTOR   | 0 0 1  | -205         | 11        | 1 10           | 1             |                                  |                           |                        |            |                |            |             | _         |            |
|               | Baltimore   Sylver   Spring   DOA   Baltimore   Sylver   Spring   DOA   Baltimore   Sylver   Spring   DOA   Baltimore   Sylver   Spring   DOA   Baltimore   Sylver   Spring   Sylver   Spring   Sylver    |  |              |           |                |               |                                  |                           |                        |            |                |            |             |           |            |

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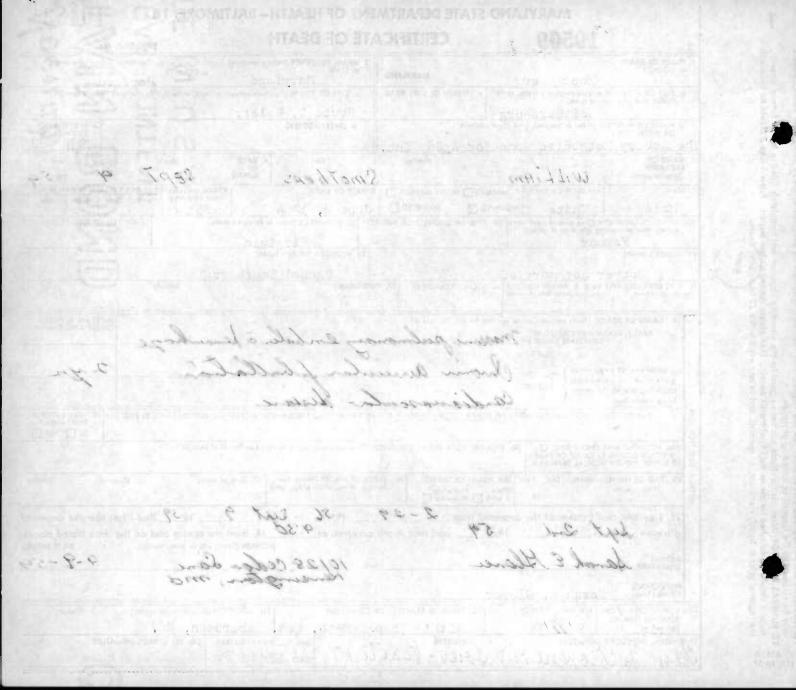
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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|  | 10509  |                 | CERTIFIC                                   | CATE OF                               | DEATH                                |                        |   | Reg. Dis      | t. No.                    |                               |
|--|--|-----------------|--|---------------------------------------|--------------------------------------|------------------------|---|---------------|---------------------------|-------------------------------|
| . PLACE OF DEATH<br>a. COUNTY                          | Montgome   | · y             | MARYLAN                                    | a STATE                               | ESIDENCE (Who                        |                        | lived. If institution b. COUNTY         | on: Residence |                           | issian)                       |
| b. CITY OR TOWN<br>RURAL and give                      | N (If autside carporate lime<br>nearest tawn)  | its, write c.   | LENGTH OF STAY IN 1                        |                                       | 11 -12 - 150                         |                        | ote fimits, write R                     |               |                           | wn)                           |
| OR INSTITUTIO  | Gaitherst SPITAL (If not in hospitol, in hos | give street add |  | d. STREE                              | T ADDRESS                            | elair                  |   | 107           | ON                        | ESIDENCE<br>A FARM?           |
| . NAME OF<br>DECEASED<br>(Type or print)               |  | rst             | Middle                                     | Cmal                                  | lost                                 | 4. DATE<br>OF<br>DEATH | Mon<br>SE A                             | th T          | Day                       | Year                          |
| . sex<br>Male  | 6. COLOR OR RACE   | 7. MARRIED      | NEVER MARRIED                              |                                       |                                      |                        | 9. AGE (In years last birthday) 75 yrs. |               | 1 YEAR IF UN<br>Days Hour | DER 24 H                      |
| Oa. USUAL OCCUPA<br>during most of w                   | ATION (Give kind of work rorking life, even if retired armer   |                 |  | oune (                                |                                      |                        | 12                                      | 12. CITI      | ZEN OF WHA                | AT COUN                       |
| B. FATHER'S NAME                                       | her not marr   | ri od           |  |                                       | R'S MAIDEN N                         | IAME                   | 80                                      |               |                           |                               |
|  | VER IN U. S. ARMED FOI   | CES? 16. SO     | CIAL SECURITY NO. 1                        | 7. INFORMANT                          | acher :                              | smothe                 | Add                                     | ress          |                           |                               |
|  |  | mass            |  | many l                                | mbale<br>John                        | de                     | tan                                     | ze            | INTERVAL<br>ONSET AN      |                               |
| lying cause fa   | ng the under- DUE TO   | Can             | LIBUTING TO DEATH                          | BUT NOT RELATED                       | Lestan<br>TO THE TERMIN              | NAL DISEASE            | CONDITION GIV                           | 'EN IN PART   | PERI                      | S AUTOP<br>ORMED?             |
| (IF EITHER, NOTI                                       | WAS UNDERLYING AND CAUSE OF DEATH (FY MEDICAL EXAMINER)  | 20Ь. DESCRI     | BE HOW INJURY OCCU                         | RRED. (Enter notus                    | e of injury in P                     | ort 1 or Port          | II of item 18.)                         |               |                           |                               |
| 20c. TIME OF INJ<br>Hour a. m<br>p. m                  | n. 10  | While _         | RY OCCURRED 20e. Not white at work         | PLACE OF INJUR<br>factory, street, or | Y (Home, form,<br>ffice bldg., etc.) | 20f. (City             | or town)                                | (C            | ounty)                    | (Sto                          |
| actual SIGNATURE                                       | that Lattended the   | 19:59           | from $2-2$<br>$\frac{1}{1}$ , and that dec |                                       |                                      | _M, fram               | the causes of ceet, city or town,       | ind on th     | e date sta                | e deced<br>ted ab<br>DATE SIG |
| NAME (Type)  O. BURIAL, CREMAT REMOVAL (Species Burial | Sarah E. G   |                 | 2c. NAME OF CEMETER Smith's Ch             | y or crematory                        |                                      |                        | ON (City, tawn, o                       |               | (St                       | ate)                          |
| FUNERAL DIRECTO  | OR'S SIGNATURE   | r YX            | ADDRESS<br>ous-Ba                          | eto.17                                |                                      | BY REGISTR             | AR 24b. REGIS                           | STRAR'S SIG   |                           |                               |

nu



CERTIFICAT

|                                   |  | MENT OF HEALTH—BALTIMORE, 18  ATE OF DEATH  Reg. Dist. No.  |
|-----------------------------------|--|---|
| Par M                             | 1. PLACE OF DEATH O. COUNTY  MONTGOMERY  MARYLANE  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY MONT GOMERY                      |
| syonid be                         | b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)  OLNEY  2 DAYS  | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)  |
| 073                               | d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL  | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \sum \) NO \( \sum \)  |
|                                   | 3. NAME OF First Middle DECEASED (Type or print) MICHAEL LEON  | SNOWDEN  4. DATE Month Day Year OF DEATH SEPTEMBER 13 19 59   |
|                                   | 5. SEX  6. COLOR OR RACE  7. MARRIED NEVER M | 9. AGE (In years left UNDER 1 YEAR IF UNDER 24 HRS.  9/11/59  9. AGE (In years left UNDER 1 YEAR IF UNDER 24 HRS.  Months Days Hours Min. |
| carban papers.                    | 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)  | DUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY:  MARY LAND USA  |
| e corbo                           | 13. FATHER'S NAME CHARLES E. SNOWDEN   | 14. MOTHER'S MAIDEN NAME  JACQUELINE JOHNSON  |
| 72 hay                            | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 [Yes, no, or unknown) (If yes, give wor or dates of service)   | HOSPITAL RECORDS, OLNEY, MD.  |
| t. Then pleass<br>y event within  | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (e).]  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  Conditions, if ony, which)   | ty a Immalurity Interval Between ONSET AND DEATH  |
| -transit permit<br>al, and in any | gove rise to immediate couse (a), stating the under-lying cause last.  | UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY   |
| + 0                               | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH B  | PERFORMED?  |

20d. INJURY OCCURRED

of work of work

MEADORS. M. D.

Not while

Mt. Zion,

ROCKVILLE, Mi.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

21. I certify that I attended the deceased fram SEPTEMBER 11 1959, ta SEPTEMBER 13,959, that I last saw the deceased

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

(County)

YES KK NO

(State)

19\_\_\_\_, and that death occurred at 10:25P M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DAMASCUS, MARYLAND 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) Bookeville, Mi. 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 2 9 '59 Bothung # Firens

20f. (City or town)

VS A15 (4) 15M 10/57

286XV

220. BURIAL, CREMATION, 226. DATE THEREOF 9/16/59

23. FUNERAL DIRECTOR'S SIGNATURE

20a. ACCIDENT WAS UNDERLYING 
OR CONTRIBUTING 
CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

Day, Year

20c. TIME OF INJURY Month,

p. m

Haur a. m.

alive an

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

| THE STATE OF HEALTH SANTAN SANTAN SANTAN SANTAN  |               |  |
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| and a pain and the state of the  | en controllès |  |
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Reg. Dist. No.

10485

| 1. PLACE OF DEATH  o. COUNTY  MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY   |
|--|--|
| b. CITY OR TOWN (If autside carporate limits, write   c. VENGTH OF STAY IN 1b  | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)   |
| RURAL and give nearest tawn  | C. C. I ON TOWN IN CONSIDER HINNINS, WHITE KOKAL ONG GIVE HEATES TOWN,   |
| d. NAME OF HOSPITAL (If not in haspital, give street oddress)  | De Silver Spring   |
| OR INSTITUTION   | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?  |
| washisan 4 Mosp.   | 8/1/1a/colm Drive YES NO B   |
| 3. NAME OF First Middle  | Lost 4. DATE Manth Day Yeor  |
| (Type or print) Bessie (none)  | Solomon DEATH 9 18 193 9   |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.   |
| J. Wh. WIDOWED DIVORCED  | 8-3, 1 62 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | STRY 11. BUTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?   |
| Housewile,   | angland. U.S.  |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |
| mr. Isaac Simon  | Rachal Mila.   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I   | NFORMANT Address   |
| [Yes, no. or unknown] (If yes, give wor or dates of service)   | 3- m Sta la C.1-   |
|  | son- Ilir slaney solomon.  |
| 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY:   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) 1 (9/X/) 4/X//   | July me ( Jala)  |
| 4201 DUE TO 0 401  |  |
| Canditions, if any, which ) (b) (Merry)  | TEGIA  |
| gave rise to immediate cause (a), stating the under-   |  |
| lying cause last.  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  | PERFORMED? YES NO  |
| 20g. ACCIDENT WAS UNDERLYING TI 20b. DESCRIBE HOW INJURY OCCURRE   | D. (Enter noture of injury in Part I or Part II of item 18.)   |
| 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING [] CAUSE OF DEATH OF LITTLE OF LITT |  |
|  | ACC OF HAMPY ALL ACC LOSS OF THE STATE OF TH |
| Hour a.m. While Not while for  | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  |
| p. m. 19 at wark at work   |  |
| 21. I certify that I attended the deceased fram /UNE V   | 19J9, ta FFT 18 19J9, that I last saw the deceased   |
| alive an SEPT 15 1, 1959, and that death   | occurred at \$30 AM from the causes and an the date stated above   |
|  | ADDRESS (Street, city or hown, state)  DATE SIGNED   |
| ACTUAL SIGNATURE WILLIAM SIGNATURE   | 1. 8773 VIMON DIAUNE 12/9/15/  |
| SIGNATURE TO THE TAXABLE TO THE TAXA | M.D  |
| PHYSICIAN'S  | College 5 10 5111 1/10   |
| NAME (Type)  | - December 14 June 1 Val   |
| BEMOVALE (Specify) 9/20-1979 LEO WASHE OF CEMETERY OF CEMETERY OF COMMENT  | REMATORY 22d. LOCATION (City, town or county) (State)  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE   |
| Soldbert Funeral Jone 410 shee   | Contesep 21 '59 Cullus & Thomas  |
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VS A1S (4) 1SM 10/57

|  |                 | (CERTIFICA)        | Town.         |  |  |
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| MARYLAND | STATE D | EPARTMEN | T OF HEALTH | -BALTIMORI | E, 18 |
|----------|---------|----------|-------------|------------|-------|
| MEDICA   | AL EXA  | MINER'S  | CERTIFICAT  | E OF DEATH | 1     |

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| \ = |  | Keg. Um. 110.   |
|-----|--|---|
| ) 1 | PLACE OF DEATH  o. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) |
| 4   | Montamory MARYLAND   | a. STATE Mad b. COUNTY Monta  |
|     | b. CITY OR TOWN (If outside corporate limits, write RURA). c. LENGTH OF STAY IN 1b and give represt flown)             | c. CiTY OR TOWN (If outside carporate limits, write RURAL and give hearest town)      |
| 1   | Clarketoking Count 21 400  | X Plankstone (Quant)  |
| 1   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   | M. STREET ADDRESS . IS RESIDENCE  |
| 1   | Burdiete Ad  | Burdelle Rf YES NO [  |
| 13  | NAME OF First Middle   | Last 4. DATE Month Day Year   |
|     | (Type or print) albert (a semin  | Somers DEATH Sept 22 1959   |
| 4   | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.   | DATE OF SIRTH 9. AGE (In your IF UNDER 14 HRS.  |
|     | male widowed Divorced  | 3-4-1887 72. yrs. Months Doys Hours Min.  |
| 1   | Oa. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                             | RY 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?           |
|     |  | 111 mac   |
|     | 13. FATHER NAME  | 14. MOTHER'S MAIDEN NAME  |
|     |  | TA. MOTIER STRAIGE STRAIG   |
| -   | Peter Somoracki  5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 117. IN                           | Rosalia Hodnidska   |
|     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN 19. (If yes, give wer or dates of service) | FORMANT Address   |
| L   | yeu www. I Ma  | il Donin (wife) Them 2  |
|     | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  | INTERVAL BETWEEN ONSET AND DEATH  |
|     | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)   | Eclusion Suddy  |
|     | 420.1 DUE TO   |   |
|     | Conditions, if any, which) (b)   |   |
|     | gave rise to immediate couse   |   |
|     | (a), stoting the underlying couse lost.  |   |
|     |  | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY       |
| 2   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO   | PERFORMED?  |
|     | 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Er   | other noture of injury in Part I ar Part II of item 18.)                              |
|     | 200. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH.  | ner notice of injury in rout to dream to a new to.                                    |
|     |  | E OF INJURY (Home, form, 20f. (City or town) (County) (Stote)                         |
| - 1 | Hour o. m. While Not while factor at work at work  | ry, street, office bldg., etc.)   |
| 1   | 21. I certify that I took charge of the remains described above  | ve, held an Autapsy , Inspection , Inquiry , and find that                            |
|     |  |   |
|     | death resolled fram: National causes 40, Accident 11, Suic   | ide [], Hamicide [], Undetermined cause [].   |
|     | ACTUAL DE 10 Paris de  | DATE SIGNED   |
|     | SIGNATURE Many Moschart  | M.D. CHIEF MEDICAL EXAMINER   |
|     | EXAMINER'S FI A SISTED STATES  | ASSISTANT MEDICAL EXAMINER  |
|     | NAME (Type) FRANK J. SOUSENELY   | DEPUTY MEDICAL EXAMINER & 9-12-37   |
| 2   | 20. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR (  | CREMATORY 22d. LOCATION (City, town, or county) (State)                               |
|     | Burial" 9/26/59 Parklawn   | Rockville, Md.  |
| 2   | 3. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS  | 240. REC'D 8Y REGISTRAR 24b, REGISTRAR'S SIGNATURE                                    |
|     | Olin L. Molesunth Damascus,  | Md. DATEP 28 '59 Onther & Kinua   |
| -   | V  |   |

THE RESERVE THE PROPERTY OF TH Books II believe

IS RESIDENCE

ON A FARM? YES NO

Year

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Day

Hours

INTERVAL BETWEEN

PERFORMED? YES NO

(Stote)

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O FUNERAL F 0 VS A15 (4) 1SM 9/SB

OR:

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220. BURIAL, CREMATION, 22b

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SIGNATURE

PHYSICIAN'S NAME (Type)

21. I certify that I attended the deceased fram.

22c. NAME OF CEMETERY OR CREMATORY

death accurred at

and mat

22d. LOCATION (City, or county) (State) 253

24a. REC'D BY REGISTRAR DATE SEP

24b. REGISTRAR'S SIGNATURE

M, fram the causes and on the date stated above.

195 that I last saw the deceased

TO STANDENTE OF SETEROLOGY A STATE OF THE STA The Mark Mark Mark Color of the Street Street Color of the Street are to a photodog of 3 of 77 4X2 12 - H With an energy while go it met Assiti - erz LANGE A- HART

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|   | Reg. Dist. No.   |
|---|--|
| 1. PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)      |
| a. COUNTY MONTHEMERY MARYLAND   | o. STATE mel b. COUNTY montey  |
| b. CITY OR TOWN (If outside priparate limits, write RURAL c. LENGTH OF STAY IN 16 and give nearest town)        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)           |
| Silvan Espring 1 w/s  | 36 Silvan Skrus  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)                                    | d. STREET ADDRESS  o. 15 RESIDENCE ON A FARM?  |
| 1701 East West Highway  | 1701 Ear West Highway YES NO   |
| 3. NAME OF DECEASED (Type or print) Hazel Emily Stan  | less de Deute de 19 1959   |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.   | DATE OF BIRTH  9. AGE (In yours left birthddy)  Manths Days Hours Min                      |
| Lungle white WIDOWED   DIVORCED   | 2-25-1902 57 yrs. Months Days Hours Min.   |
| 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTI                                   | RY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTR                    |
| housewife own home  | 1 ta 19-3 a  |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |
| George P. Stryker   | Emily Long   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN                                     | FORMANT Address  |
| no  | estie W Stanley - Slin 2   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]                                       | INTERVAL BETWEEN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |
| 974× DUE TO   | Dudden   |
| Conditions, if any, which) (b) have   |  |
| gave rise to immediate couse (o), stating the underlying DUE TO   |  |
| couse lost. (c)   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N   | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| CAI   | YES NO   |
| I ≈ I FRIMARI LI OF CONTRIBUTING AN   | nter noture of injury in Port I or Port II of item 18.)                                    |
| CAUSE OF DEATH.   | - nech at home   |
|   | EFOF INJURY (Home, form, 20f. (City or town) (County) (State)                              |
| Hour p. m. 9-19 1969 While Not wifile of work of work   | Rome Selvas They muity my  |
| 21. I certify that I took charge of the remoins described above   | ve, held on Autopsy . Inspection Inquiry . ond find the                                    |
| deoth resulted from: Notural couses, Accident, Suic   | cide 🔀, Homicide 🔲, Undetermined cause 🔲.  |
|   |  |
| SIGNATURE Trank 1. Directuck  | M.D. CHIEF MEDICAL EXAMINER  |
| EVANDAGE FE   | ASSISTANT MEDICAL EXAMINER   |
| EXAMINER'S FLANK J. Broschart   | DEPUTY MEDICAL EXAMINER D 7- 19-59   |
| 220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR OF REMOVAL (Specify) 9/23/59 ARI.TNGTON NAT*I | (51515)  |
| 7,47,77   |  |
| WARNER E. PUMPHREY, INC. SILVER SPRING.   | MD 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE                                      |
| Raymond A. Ziska!   | DATEEP 23 '59 Orthur & trans   |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

| 30.00 | MEDICAL EXAMINERS CERTIFICATE OF DEATH   |
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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10514 CERTIFICATE OF DEATH

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| 1   |          |  | 7007                                 | Z.                     | CEKTIFI         | CAII       | OF DEAL  | In .             |                               | Reg.          | Dist. No.       |           |       |
|-----|----------|--|--------------------------------------|------------------------|-----------------|------------|--|------------------|-------------------------------|---------------|-----------------|-----------|-------|
| M   | 1.       | Montgode:  | ry                                   |                        | MARYLA          |            | JSUAL RESIDENCE (Vo. STATE Marylai             |                  | ed lived. If insti<br>b. COUN | NTY           | lence befor     |           |       |
| Inn |          | D. CITY OR TOWN (If outside<br>RURAL and give nearest to                   | corporate limits,                    | write c. LEt           | NGTH OF STAY IN | 1b         | . CITY OR TOWN (I                              |                  | orote limits, writ            |               |                 |           |       |
|     |          | Bethes   |                                      | street address         | 26 Hrs          | ·X         | Bethe:   | sda              |                               |               | Т.              | e. IS RES | IDENC |
| 74  |          | OR INSTITUTION   | urban He                             |                        | *               |            | 7819 7819                                      | Overh            | :11 Ra                        |               |                 | ON A      | FARA  |
|     |          | NAME OF<br>DECEASED  | First                                | TE OF                  | Middle          |            | Last   | 4. DATE<br>OF    |                               | Month         | Da              | ,         | Year  |
|     |          | Type or print)   | Ella                                 |                        | Α.              |            | itz  | DEATH            |                               | Sept.         | 30<br>ER I YEAR |           | 18 50 |
|     |          | F  |                                      | IDOWED [               | DIVORCED [      |            | TE OF BIRTH                                    |                  | 9. AGE (In year lost birthdo  |               |                 | Hours     | M     |
|     | 10a      | USUAL OCCUPATION (Give<br>during most of working life,                     | kind af wark dan<br>even if retired) |                        |                 | NDUSTRY    | 11. BIRTHPLACE (Sta                            | te ar foreign o  | country)                      | 12.C          | ITIZEN OF       | WHATC     | OUN   |
| . } | 13       | Homemaker<br>FATHER'S NAME   |                                      | Own                    | Home            | 14         | Brookl.  |                  | York                          |               | U               | S.A       | -     |
| 1   | , ,      |  |                                      |                        |                 |            |  |                  |                               |               |                 |           |       |
|     |          | WAS DECEASED EVER IN U.  | S. ARMED FORCES                      |                        | L SECURITY NO.  | INFOR      | MANT Loui:                                     | s e fr           | ink                           | Address       |                 |           |       |
|     |          | , no, or unknown) (If yes, giv   | e war ar dates of service            |                        |                 | (D         |  | Tr'a             | 7.7                           |               |                 |           |       |
|     | 147      | 18. CAUSE OF DEATH [En   | ter only one cause                   |                        |                 | (Daug      | nter) M-r                                      | s. Ples          | n or                          | lowe          | INTE            | RVAL BE   | TWI   |
| 410 |          | PART I. DEATH WAS  | CAUSED BY:                           | 0                      |                 |            | a. te  | is               |                               |               | ONS             | ET AND    | DE    |
|     |          | 153 8 IMMED  | DUE TO                               |                        | vycz            | 100        | 1  | 7                |                               |               |                 |           |       |
|     |          | Canditians, if any, whi  | -6 \                                 | 1                      | 1-0             |            | 1 la   |                  | 1-                            | ~ 0           |                 |           |       |
|     | H        | gave rise to immedia   | ote (DUE TO                          | Can                    | Con             | 21-6       | 7  | 192              | 000                           | 22            |                 |           |       |
| 1   |          | lying couse lost.  | er-                                  |                        |                 |            | 0  |                  |                               |               |                 |           |       |
|     | NO       |  | ) (c)<br>NIFICANT CONDIT             | IONS CONTRI            | BUTING TO DEATH | BUT NOT    | RELATED TO THE TER                             | MINAL DISEAS     | SE CONDITION                  | GIVEN IN P    | ART 1(o) 1      |           | AUTC  |
| 0   | ATIC     |  |                                      |                        |                 |            |  |                  |                               |               |                 | PERFO     |       |
| 8   | CERTIFIC | 20a. ACCIDENT WAS UNDE<br>OR CONTRIBUTING CAL<br>(IF EITHER, NOTIFY MEDICA | RLYING 201                           | b. DESCRIBE H          | IOW INJURY OCC  | URRED. (Er | ter noture af injury i                         | n Port I or Po   | rt II of item 1B.)            |               |                 |           |       |
|     | _        |  |                                      |                        |                 | 01105      |  | 1 222 1 231      |                               |               |                 |           |       |
|     | MEDICA   | 20c. TIME OF INJURY Mon<br>Haur o. m.                                      | 10                                   | 20d. INJURY<br>While N | lot while       | foctory,   | OF INJURY (Home, fo<br>street, office bldg., o | irm,   201. (Cit | y or town)                    |               | (County)        |           | (:    |
|     | WE       | p. m.  | 19                                   | ot work 🔲 a            | t work          | , _        | -  | 1                | - 0                           |               |                 |           |       |
|     |          | 21. I certify that I a   | ttended the de                       | eceased fro            | m               | 1.3        | , 195 % ta_                                    | 7/3              | 19                            | fhat I        | last saw        | the d     | ece   |
| 150 |          | alive an 7-2   | - g                                  | 1217                   | _, and that de  | eath oc    | curred at 113                                  |                  | the causes                    |               | he date         | ,         |       |
|     |          | ACTUAL   | 2/15                                 | //                     |                 |            | dial m.  | ADDRESS (S       | Street, city or to            | wn, stote)    | 9               | DAT       | E 21  |
|     |          | SIGNATURE  | 1-/                                  | 47                     | 4-2             | M.D.       | 106 114  | Tou!             | inge                          | FOX           |                 | 100       | 1     |
| /   |          | PHYSICIAN'S<br>NAME (Type) Tye 7 7 2                                       | 4                                    |                        |                 |            | 13   | elhe.            | de,                           | m             |                 |           |       |
|     | 22a      |  | DATE THEREOF                         | 22c.                   | NAME OF CEMETE  | RY OR CR   | MATORY   | 22d. LOCA        | ATION (City, tow              | rn, or county | 1)              | (Stot     | e)    |
| 7   | ra       | ns-Bur. 1  | 9-3-59                               | M                      | . Olive         | et Co      | em.  | Que              |                               | unty,         |                 |           | rk    |
|     | -        | FUNERAL DIRECTOR'S SIGNA   |                                      |                        | DDRESS          |            | 24a. R   | CD BY REGIS      |                               | EGISTRAR'S    | SIGNATUR        | E         |       |
| H   | 10       | pert A. Pump   | pnrey,                               | Bethes                 | sda, Mar        | rylai      | ld DATE  | 70.07            |                               | ~~~~~         | r, / Made       |           |       |

TOST & CERTIFICATE OF DEATH Label and a regard with the control of the Agraph and stone A STORY THE TOTAL STORY AND LAND I THE And the state of t And the mains of a contract of the second of Trans-her. Oraz-ni Pt. oliver nea. ottora Granty New York

| ICATE OF DEATH | Reg. Dist. No. 21 |
|----------------|-------------------|
|                |                   |

| _             |  | 1051                                 | -              |                        |          |  |                   |                                    | Keg. L    | 7151. INO | . 21)      |          |  |
|---------------|--|--------------------------------------|----------------|------------------------|----------|--|-------------------|------------------------------------|-----------|-----------|------------|----------|--|
|               | PLACE OF DEATH o. COUNTY Montgome                            | rv                                   | J              | MAR                    | YLAND    | 2. USUAL RESIDENCE<br>o. STATE<br>Vorgini  |                   | ed lived. If institution b. COUNTY | on: Resid | ence befo | re admissi | on)      |  |
|               | b. CITY OR TOWN (If<br>RURAL and give nee                    | outside corporate limi               | its, write     | c. LENGTH OF STA       | Y IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |                   |                                    |           |           |            |          |  |
|               | Bethesda   | (Rural                               | )              | 55 days                |          | Falls C  | hurch             | 8:                                 | 3 X -     | 3         |            |          |  |
|               | d. NAME OF HOSPITA<br>OR INSTITUTION<br>U.S. Nav             | al Hospi                             | tal.           | oddress)<br>Bethesda   | Md.      | d. STREET ADDRES   | s<br>futt I       | rive                               |           |           |            | PARM?    |  |
| 3.            | NAME OF  | Fig                                  |                | Middl                  |          | Last   | 4. DATE           | Mon                                | th        | Do        |            | rear Las |  |
|               | DECEASED<br>(Type or print)                                  | Jose                                 |                | Fred                   |          | STEPHENS   | OF                | Septemb                            |           | 24        | 1          | 19 59    |  |
| S.            | SEX  | 6. COLOR OR RACE                     |                | IED NEVER MARK         |          | B. DATE OF BIRTH   |                   | 9. AGE (In years lost birthdoy)    | -         | -         | IF UNDE    | -        |  |
| 1             | Male   | White                                | WIDOWE         |                        |          | 1-5-34   |                   | lost birthdoy)<br>25 yrs.          | Months    | Doys      | Hours      | Min.     |  |
|               | . USUAL OCCUPATIO  | N (Give kind of work                 | done 10b.      | KIND OF BUSINESS       | OR INDU  | STRY 11. BIRTHPLACE (S   | itate or fareign  | country)                           | 12. C     | TIZEN O   | F WHAT C   | OUNTRY?  |  |
| 1             | Service s  | ing life, even if retired<br>station | C              | ommercia               | 1        | New Je   | rsev              |                                    | 1         | J.S.      |            |          |  |
|               | Autendant  |                                      |                |                        |          | 14. MOTHER'S MAIDE   |                   |                                    |           |           |            |          |  |
| V             | Villiam E  | . STEPHE                             | NS             |                        |          | Cather   | ine CC            | NTE                                |           |           |            |          |  |
|               | WAS DECEASED EVER  | IN U. S. ARMED FOR                   |                | SOCIAL SECURITY N      | 0. 1     | NFORMANT   |                   | Add                                | ress      |           |            |          |  |
| 1             |  | 953-1955                             | 5              | 35 32 57               | 77 (     | (Wife) Bar   | bara J            | Stephe                             | ns        | Same      | as         | #2       |  |
|               | 1B. CAUSE OF DEAT  | TH [Enter only one co                | use per lir    | e for (o), (b), and (c | ).]      |  |                   | 1 . 1                              |           | INT       | ERVAL BE   |          |  |
|               |  | TH WAS CAUSED BY:                    |                | sel Da                 | 140      | Aprilat  | 011.              | Xvilu                              | re        | ON        | SET AND    | DEATH    |  |
|               | 201X   | DUE TO                               |                |                        |          |  | 7                 | 1                                  |           |           |            |          |  |
|               | Conditions, if on  | y, which )                           | · L            | adax.                  | 1-00     | Nine   | nel.              | V                                  |           |           |            |          |  |
|               | gove rise to in  |                                      | ) <del></del>  |                        |          |  |                   |                                    |           |           |            | -        |  |
|               | couse (o), stating t<br>lying couse lost.                    | he under-                            | 1              |                        |          |  |                   |                                    |           |           |            |          |  |
| Z             | PART II. OTH   | ER SIGNIFICANT CON                   | IDITIONS C     | ONTRIBUTING TO D       | EATH BUT | NOT RELATED TO THE TE  | ERMINAL DISEAS    | SE CONDITION GIV                   | EN IN PA  | RT 1(o)   | 19. WAS /  | AUTOPSY  |  |
| KATI          | 1,000  |                                      |                |                        |          |  |                   |                                    |           |           |            | RMED?    |  |
| CERTIPICATION | 20a. ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY I | ☐ CAUSE OF DEATH                     | 20b. DESC      | CRIBE HOW INJURY       | OCCURRE  | D. (Enter noture of injury   | y in Port I or Po | rt II of item 1B.)                 |           |           |            |          |  |
|               | 20c. TIME OF INJURY  | Month, Doy, Ye                       | or 20d. IN     | NJURY OCCURRED         |          | ACE OF INJURY (Home,   | farm, 20f. (Cit   | y or town)                         |           | (County)  |            | (Stote)  |  |
| MEDICAL       | Hour o.m.  | 19                                   | While of world | Not while of work      | fo       | ctory, street, office bldg.,   | , etc.)           |                                    |           |           |            |          |  |
|               | 21. I certify the  | at I attended the                    | decens         | ed from 31 J           | ulv      | 1959 ta  | 24 Ser            | t 1959                             | that I    | last say  | v the d    | eceased  |  |
|               |  | Septembe                             |                | 59 and the             | t death  | occurred at 11:  |                   |                                    |           |           |            |          |  |
|               |  |                                      |                |                        | .,       | 00001100 012222  |                   | Street, city or town,              |           | ic dan    |            | E SIGNED |  |
|               | ACTUAL   | 10/1800                              | M.             | 1 Dake                 | N        | M.D. U.S. Na   | aval Ho           | ospital,                           | Be        | thes      | da I       | Id.      |  |
|               | 00   | Jacob Mr.                            | 4              |                        |          |  |                   |                                    |           |           | 9-1        | 25-5     |  |
|               | PHYSICIAN'S<br>NAME (Type) W                                 | P. BAKER                             | LT             | MC USN                 |          | U.S. Na  | aval Ho           | spital,                            | Bet:      | hesc      | la Mo      | 1.       |  |
| 220           | BURIAL, CREMATION  | , 22b. DATE HEREC                    | )F             | 22c. NAME OF CEA       | METERY O | R CREMATORY  | 22d. LOCA         | TION (City, town,                  | or county | )         | (Stote     | e)       |  |
| BI            | REMOVAL (Specify)  | 0/29-F                               | 59             | Arlingt                | on 1     | Vational   | Ari               | ington                             | Vi.       | rgir      | nia        |          |  |

TO FUNERAL page 3 shauld TO HOSPITAL may be retai VS A1S (4) 1SM 9/SB

TOR: After this certificate has been signed by the attending physician and campletely filled in by

the haspital ar attending physician. be detached far use as the burial-transit

crematian, ar remayal, and in any event within 72 hours after death. permit.

the registrar priar ta burial,

MERAL DIRECTOR'S SUSNATURE

Then please remave carban papers.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haur

051

pup

7557 WisconsinarAve. Bethesda Md. rumphrev Home Fundral SEP 3 0 '59

ADDRESS

Arlington National

arthur & Trans

24b. REGISTRAR'S SIGNATURE

Virginia

Arlington

24a. REC'D BY REGISTRAR

HIPART TO THAT HE STATE OF THE OF slingueV VremoginoM struct ligarital police of the control of the contr The statement of the st Men 19 Hillings to a strictle barbane d. Stephone Jane as as . bit attacked to the control of the Townson of the special lover But - MED on in MED and the special Medical A MY primpted Fundral Hate VEE Massens and very Harberts and

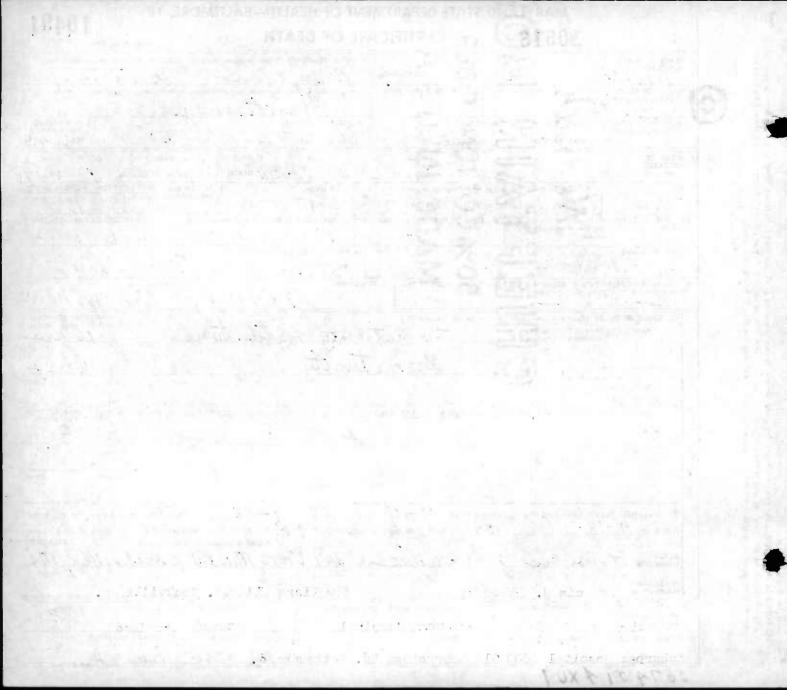
VS A15 (4) 15M 9/5B 2

| MARYLAND | STATE | DEPARTMENT | OF | HEALTH-BALTIMORE, | 18 |
|----------|-------|------------|----|-------------------|----|
|          |       |            |    |                   |    |

10516 CERTIFICATE OF DEATH

10491 Reg. Dist. No.

| 1. PLACE OF DEATH  o. COUNTY  MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY  |
|--|---|
| b. CITY OR TOWN (I) outside corporate limits, write RURAL and give regress town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Advantage  Acquited  | d Syreet Address    d Syreet Address   6. Is residence On a FARM? YES   NO  |
| 3. NAME OF DECEASED (Type or print)  BABY Middle (Type or print)   | STEVENSUNDEATH SEPTEMBER 18 19 59   |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   TETALR   Colored   WIDOWED   DIVORCED   | B. DATE OF BIRTH Sept 17, 1959 9. AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |
| 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | USTRY 11. BIRTHPLACE (Stote or foreign cauntry)  12. CITIZEN OF WHAT COUNTRY?  12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME NOT GIVEN  | 14. MOTHER'S MAIDEN NAME BETTY ANN STEVENSON  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes, give war or doles of service)  | INFORMANT POTHER. SANEAS ABOUTE   |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  | turity + atelectors Interval BETWEEN  |
| Conditions, if ony, which gove rise to immediate cause (a), stoting the <u>under-lying couse lost.</u> DUE TO  Premie  | turity 16hrs  |
|  | IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?  YES \( \bigcirc \) NO \( \bigcirc \)  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT TO DEA | ED. (Enter noture of injury in Port I or Port II of item 18.)   |
|  | LACE OF INJURY (Home, form, octory, street, office bldg., etc.) (City or town) (County) (Stote)   |
| 21. I certify that I attended the deceased fram 9-17 alive an 9-18-, 1959, and that death  ACTUAL SIGNATURE Francis J. TROENDIE  | h accurred at 1 P. M., from the causes and an the date stated abave.  ADDRESS (Street, city or town, stote)  M.D. 809 Viers Mill Rd. Rockville, Md.  809 Viers Mill Rd. Rockville Md. |
| 22c. NAME OF CEMETERY C<br>REMOVAL (Specify) 9-18-59 Suburban Host   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| Suburban Hospital 8600 Old Georgetown  | Rd. Bethern MCI 6'59 Cashing & House  |
| 2074214XU1   |   |



VS A1S (4) 15M 9/58

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

10492 Reg. Dist. No.

| PLACE OF DEATH   |  |   |                    |  |  |                   |   |
|--|--|---|--------------------|--|--|-------------------|---|
| 140076   | omeru  |   | MARYLAND           | 2. USUAL RESIDENCE (Where de a. STATE                            | b COUNTY   | n: Residence befo |   |
| b. CITY OR TOWN<br>RURAL and give                      | (If autside carporate limits, nearest tawn)                      | 0.6   | OF STAY IN 16      | c. CITY OR TOWN (If autside                                      |  |                   |   |
|  |  |   | 2412               | d. STREET ADDRESS SOUTH LAWN                                     | LANE   |                   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| NAME OF<br>DECEASED<br>(Type or print)                 | RAYMO  |   | Middle             | Last 4. D  | ATE Mant   |                   | y Year 1957                             |
| MALE   |  | MARRIED NEVE  | R MARRIED DIVORCED | 8. DATE OF BIRTH  12/15 1876                                     | 9. AGE (In years last birthday)  | Manths Days       | Haurs Min                               |
| Oa. USUAL OCCUPAT                                      | 111000   |   |                    | STRY 11. BIRTHPLACE (State or ford                               |  |                   | F WHAT COUNTR                           |
| 3. FATHER'S NAME                                       |  |   |                    | 14. MOTHER'S MAIDEN NAME   | 100-   |                   | 3.77                                    |
| S. WAS DECEASED EV                                     | ER IN U. S. ARMED FORCE<br>(If yes, give war or dates of servi   | S? 16. SOCIAL SECU                                  | JRITY NO.          | NFORMANT (SIST   | S VONE Address | LUCK              | oore A                                  |
| 18. CAUSE OF DE  | ATH [Enter anly one cause ATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | per line far (a), (b)                               | and (c).]          | Pront fail   | luce   | INT               | ERVAL BETWEEN<br>SET AND DEATH          |
| Candilians, if   | DUE TO   | Ante  | Tion -             | lerotie H  | 0  |                   | yrs                                     |
| gave rise ta<br>cause (a), stating<br>lying cause last | the under-   |   |                    |  |  |                   | 0                                       |
|  | HER SIGNIFICANT CONDIT   | TIONS CONTRIBUTION                                  | G TO DEATH BUT     | NOT RELATED TO THE TERMINAL D                                    | E meles  | EN IN PART 1(a)   | PERFORMED?  YES NO                      |
| OR CONTRIBUTING  | AS UNDERLYING 1 20<br>G CAUSE OF DEATH<br>MEDICAL EXAMINER)      | b. DESCRIBE HOW                                     | NJURY OCCURRE      | D. Conter nature af injury in Part I o                           | ar Part II af item 18.)  |                   |   |
| 20c. TIME OF INJU<br>Haur a. m.<br>p. m.               | RY Manth, Day, Year<br>19  | 20d. INJURY OCCU<br>While Nat wh<br>at wark at wark | ile fa             | ACE OF INJURY (Hame, farm, 20fctary, street, affice bldg., etc.) | . (City ar tawn)   | (Caunty)          | (Stat                                   |
| 21. I certify alive an                                 | hat I attended the d   |   |                    | 1957, ta 9-1   | •  |                   | w the decease<br>e stated abov          |
| ACTUAL SIGNATURE                                       | Bond   | elet He   | inter!             | M.D  | ESS (Street, city ar tawn, s   | state)            | 9/14/                                   |
| PHYSICIAN'S<br>NAME (Type)                             |  |   |                    | <u> </u>   |  |                   | , ,                                     |
| 2a. BURIAL, CREMATION REMOVAL (Specify                 | 9/18/59  |   | of CEMETERY O      | R CREMATORY 22d.   | Rockville,   | Md.               | (State)                                 |

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VS A15 (4) 15M 10/57

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| F. E |   | 1 |

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#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10368

CERTIFICATE OF DEATH

Rea. Dist. No.

10493

| 1. PLACE OF DEATH o. COUNTY  |  | MAP                            | YLAND                | 2. USUAL RESIDENCE (WHO o. STATE                           | ere deceased lived.              | If institution: Resid | ence befare ad      | missian)               |
|--|--|--------------------------------|----------------------|--|----------------------------------|-----------------------|---------------------|------------------------|
| b. CITY OR TOWN (If outside corp   |  |                                |                      | Maryla   | nd                               | Mor                   |                     | ery                    |
| RURAL and give nearest town)   | orose limits, write                    | c. LENGTH OF STAY              | IN ID                | c. CITY OR TOWN (If a                                      | iutside carporate lim            | its, write RURAL and  | d giyê nearest t    | own)/                  |
| Takoma   | Tark.                                  |                                | /                    | 17a.Kon  | 7a Fa                            | RK                    |                     |                        |
| d. NAME OF HOSPITAL (If not in I<br>OR INSTITUTION                                       | hospital, give street od               | ldress)                        |                      | d. STREET ADDRESS  | . 1                              | 0/                    |                     | RESIDENCE<br>N A FARM? |
| Washington   | Danilas                                | 14 my y the                    | 25p                  | 1224-1   | MINTER                           | Mac                   | YES YES             | □ NO □                 |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br>-le NN                        | Middle                         | mas                  | 10st < 105   | 4. DATE<br>OF<br>DEATH           | Month                 | Day                 | Year 19.55             |
| 5. SEX 6. COLOR C  | OR RACE 7. MARRIE                      |                                |                      | DATE OF BIRTH  | 9. AGE                           |                       | ER 1 YEAR IF U      | NDER 24 HRS.           |
| Male W   | WIDOWED                                | DIVORC                         | ED 🗌                 | 6-11-19  | 04 S                             | birthday) Months      | Doys Hou            | ors Min.               |
| Oa. USUAL OCCUPATION (Give kind during mast of working life, even                        | of work done 10b. KI                   | ND OF BUSINESS                 | OR INDUSTR           | 11. BIRTHPLACE (Stote                                      | or foreign country)              | 12. 0                 | ITIZEN OF WE        | HAT COUNTRY            |
| ENGINCER   | il.                                    | . S. Gove!                     | 1-                   | NorTh  | Caro                             | lina                  | 4.5                 | . FI-                  |
| 3. FATHER'S NAME   |  |                                |                      | 14. MOTHER'S MAIDEN N                                      | IAME                             |                       |                     |                        |
| -John  | 5711                                   | ES                             | . 163                | MaTT   | ie V                             | ohns                  | 0 12                |                        |
| 5. WAS DECEASED EVER IN U. S. AR   |  | DCIAL SECURITY NO              | ). 17. INF           | ORMANT   |                                  | Address               | Tokowa              | PORK                   |
| Vesilan 1942   | or dates of service) - 1945            |                                | MI                   | 25. Ruth   | STILES                           | 7229                  | Minte               | or Plac                |
| Conditions, if ony, which gove rise to immediate cause (o), stating the under-           |  | CRRHAG                         | E, 50                | IBARA CHN  | oin Bisil                        | AR, MASS              | INTERVAL<br>ONSET A | BETWEEN<br>ND DEATH    |
| lying couse lost.  | (c)                                    | ALTERNITING TO DI              | ATU DUT AL           | OT BELLATED TO THE TERMIN                                  | NAME DISCOURT                    | IVION CONTRACTOR      |                     | AC ALITORSY            |
| 3  | ANT CONDITIONS CO                      | NIKIBUTING TO DE               | AIN BUT NO           | OT RELATED TO THE TERMI                                    | NAL DISEASE CONL                 | THON GIVEN IN PA      | PE                  | RFORMED?               |
| 20a. ACCIDENT WAS UNDERLYIN<br>OR CONTRIBUTING CAUSE O<br>(IF EITHER, NOTIFY MEDICAL EXA | NG [] 20b. DESCR<br>F DEATH<br>AMINER) | IBE HOW INJURY O               | OCCURRED.            | Enter noture of injury in F                                | Port 1 or Part 11 of it          | em 18.)               |                     |                        |
| 20c. TIME OF INJURY Month,<br>Hour o. m.<br>p. m.  | While                                  | URY OCCURRED Nat while ot work | 20e. PLACI<br>foctor | E OF INJURY (Home, farm,<br>ry, street, office bldg., etc. | 20f. (City or town)              | n)                    | (Caunty)            | (State)                |
| 21. I certify that I attend alive an   | ded the deceased 7, 1959  Harana       | and that                       | death a              | ccurred at 350 A   | M, fram the ADDRESS (Street, cit |                       |                     |                        |
| REMOVAL (Specify) Dopp   | -22:59                                 | 22c NAME OF CEM                | EYERY ORG            | REMATORY, eliqual  | 220 LOCATION (C                  | ty, town, or county   | 1/200               | itote)                 |
| 3. FUNERAL DIRECTOR'S SIGNATURE  | 12                                     | ADDRESS A                      | 11                   | A Day DECI   | BY REGISTRAR                     | 24b. REGISTRAR'S S    | Chiarelpe           |                        |

W

| -  | -  | - |   | - |
|----|----|---|---|---|
| 1  | 41 | 5 | 7 | • |
| 2. | U  | U | ı | O |

CERTIFICATE OF DEATH

| 1. PLACE OF DEATH  |  |  |  |  |   | ist. No.   |
|--|--|--|--|--|---|--|
| a. COUNTY  | Montgomery   | MARYLAND   | 2. USUAL RESIDENCE (W  |  | COUNTY  | ence before admission)   |
| b. CITY OR TOWN  | (If outside corporate limits, writ   | e c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (IF  |  |   | give nearest town)   |
| RURAL and give   | neorest town)  | 71 days  |  |  | 774   | 3  |
|  | PITAL (If not in hospital, give str  |  | d. STREET ADDRESS  | 18.  | / / / /   | e. IS RESIDENCE  |
|  | ical Center, Be  | ethesda 14, Md.  | Route  | # 1  |   | ON A FARM?   |
| 3. NAME OF<br>DECEASED   | First  | Middle   | Lost   | 4. DATE  | Manth   | Day Year   |
| (Type or print)  | Christine  | Mabell   | Swafford   |  | tember  | 27 19 59   |
| S. SEX   | 6. COLOR OR RACE 7. M  | ARRIED TO NEVER MARRIED  | B. DATE OF BIRTH   | 9. AGE   |   | R 1 YEAR IF UNDER 24 HR  |
| Female   |  | OWED DIVORCED  | March 3, 192   | 29 3   | O yrs. Months   | Days Hours Min.  |
| IOa. USUAL OCCUPAT   | TION (Give kind of work dane 1 orking life, even if retired)   | Ob. KIND OF BUSINESS OR INDU   | STRY 11. BIRTHPLACE (Stote   | or foreign cauntry)  | 12. CI  | TIZEN OF WHAT COUNT  |
| Textile W  |  | Textile Industr  | y South Car  | olina  |   | U. S. A.   |
| 3. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN I  |  | 1   |  |
| George Co.   | llins  |  | Minnie SI  | oan  |   |  |
|  | /ER IN U. S. ARMED FORCES?   | 16. SOCIAL SECURITY NO.   17. II   | NFORMANT The Med   |  | and Address   |  |
| no no or unknown)  |  |  | The Clinical   |  |   | Mameland   |
| IB. CAUSE OF D   | EATH [Enter only one couse pe  |  |  | 0011001  | ourobud 2   | INTERVAL BETWEEN   |
|  |  | enocarcinoma, P  | dware Task   | T  |   | ONSET AND DEATH  |
| 1100   | IMMEDIATE CAUSE (o)  | miocarerions, P.   | Limara, Pere   | Time   |   | 4 Months   |
|  |  |  |  |  |   |  |
| 162,1  | DUE TO   |  |  |  |   |  |
| Canditians, if   | any, which ) (b)   |  |  |  |   |  |
| Canditians, if gave rise to  | any, which (b)   |  |  |  |   |  |
| Canditians, if   | any, which (b)<br>immediate<br>g the <u>under-</u>   |  |  |  |   |  |
| Canditians, if<br>gave rise to<br>cause (o), stating<br>lying cause last   | any, which immediate g the under: (b) DUE TO   | IS <u>Contributing to</u> death but  | NOT RELATED TO THE TERMI   | NAL DISEASE COND   | ITION GIVEN IN PAI  | RT 1(a) 19. WAS AUTOPS   |
| Canditians, if<br>gave rise to<br>cause (o), stating<br>lying cause last   | any, which immediate g the under: (b) DUE TO   | NS <u>CONTRIBUTING TO DEATH</u> BUT  | NOT RELATED TO THE TERMI   | nal disease cond   | ITION GIVEN IN PAI  | PERFORMED?   |
| Canditians, if gave rise to cause (o), statim, lying cause lost  | any, which immediate g the under (c) DUE TO (c) THER SIGNIFICANT CONDITION   | AS <u>CONTRIBUTING TO DEATH</u> BUT<br>DESCRIBE HOW INJURY OCCURRED  | •  |  |   | RT 1(a) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO                                |
| Canditians, if gave rise to cause (o), stating lying cause lost  PART II. O  | any, which immediate g the under. (b)  DUE TO (c)  THER SIGNIFICANT CONDITION  |  | •  |  |   | PERFORMED?   |
| Canditians, if gave rise to cause (o), statim lying cause lost  PART II. O  PART II. O  CONTRIBUTING  OR CONTRIBUTING  (IF EITHER, NOTIF   | any, which immediate g the under   DUE TO  | DESCRIBE HOW INJURY OCCURRED   | D. (Enter nature of injury in  | Part I or Part II of ite   | em 1B.)   | PERFORMED? YES NO  |
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| Canditians, if gave rise to cause (o), stating lying cause lost  PART II. O  20a. ACCIDENT WOOR CONTRIBUTING (IF EITHER, NOTIFE HOUR o, m. p. m.   | any, which immediate g the under. DUE TO (c)  THER SIGNIFICANT CONDITION  VAS UNDERLYING  CAUSE OF DEATH Y MEDICAL EXAMINER)  JRY Manth, Doy, Year 200, Wh. 19   | DESCRIBE HOW INJURY OCCURRED  I. INJURY OCCURRED  ile Not while for work discovering at work discovering the control of the co | O. (Enter noture of injury in<br>ACE OF INJURY (Home, form<br>tory, street, office bldg., etc  | Part I or Part II of ite   | em 18.)<br>1) (   | PERFORMED? YES ■ NO □  (County) (State   |
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| Canditians, if gave rise to cause (o), statim lying cause lost PART II. O  20a. ACCIDENT W 20a. ACCIDENT W 20c. TIME OF INJU-Hour a. m. p. m.  21. I certify alive an Sel  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)  | any, which immediate g the under. DUE TO  THER SIGNIFICANT CONDITION  WAS UNDERLYING   206. E  G   CAUSE OF DEATH  Y MEDICAL EXAMINER)  JRY Manth, Doy, Year 206  What I attended the deceptember 27, 15   | DESCRIBE HOW INJURY OCCURRED  I. INJURY OCCURRED  I. Not while  work at work  assed fram July 18  2.59, and that death   | ACE OF INJURY (Home, form tory, street, office bldg., etc., 19 59, to Se occurred at 2:00  Nationa  Bethesd                                    | Part I or Part II of ite  20f. (City or town  ptember 2  PM, fram the cappress (Street, city  nical Cen  | 719.52, that 1 causes and an it or town, stote) ter tes of He                                 | (County) (State  |
| Canditians, if gave rise to cause (o), statim lying cause lost PART II. O  PART II. O  20a. ACCIDENT W ON CONTRIBUTING (IF EITHER, NOTIRE Hour a.m. p. m.  21. I certify alive an Sel ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)   | any, which immediate g the under. DUE TO  THER SIGNIFICANT CONDITION  VAS UNDERLYING   20b. E   20c.   20c. | DESCRIBE HOW INJURY OCCURRED  I. INJURY OCCURRED  II. Not while work at work at work at work at work at work  Description of the second of the | ACE OF INJURY (Home, form tory, street, office bldg., etc., 19 59, to Se occurred at 2:00  Nationa  Bethesd                                    | Part I or Part II of ite  20f. (City or town  ptember 2  PM, fram the capabass (Street, city  nical Cen  1 Institu   | 719_52, that 1 causes and an it or town, state) ter tes of Helyland                           | (County) (State date stated aba DATE SIGN 9-28-5)                              |
| Canditians, if gave rise to cause (o), stating lying cause lost Part II. O Part III. O Par | any, which immediate g the under. DUE TO (c)  THER SIGNIFICANT CONDITION  VAS UNDERLYING   20b. E (c)   | DESCRIBE HOW INJURY OCCURRED  I. INJURY OCCURRED  II. Not while work at work at work at work at work at work  Description of the second of the | ACE OF INJURY (Home, form tory, street, office bldg., etc., 1959, to Se occurred at 2:00  M.D. The Cli  Nationa  Bethesd                       | Part I or Part II of ite  20f. (City or town  ptember 2  PM, fram the cappress (Street, city  nical Cen  1 Institu  211. Mar  22d. LOCATION (City  22d. LOCA | 719.59, that I causes and an ity or town, state)  ter  tes of Heryland  ity, town, or county) | (County) (State last saw the decease the date stated abanase Sign 9-28-55 alth |

r death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL CONTROL FOR After this certificate has been signed by the ottending physician and campletely filled in by the funeral director, page 3 should as detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or remayal, and in any event within 72 house after death. TO HOSPITAL OR ATTENDING PHYSICIAN; The low requires that the death certificate be executed within 24 haurs

VS A15 (4) 15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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|----------------|---|---|--|------------------------------------|----------------|------------------|--|-------------|-------------|---------------------------------|
| 1              | LACE OF DEATH<br>I. COUNTY<br>Montgomery                            | 7   | MARYLAND   | 2. USUAL RES<br>a. STATE<br>Flor   | idence (Wh     | ere deceased     | lived. If institution by COUNTY. Pine. |             | e befare ad | Imissian)                       |
| ŧ              | CITY OR TOWN (If au RURAL and give neare:                           | tside carporate limits, write                               | c. LENGTH OF STAY IN 15  | c. CITY OR                         | TOWN (If a     | utside carpora   | ate limits, write R                    | URAL and gi | ive nearest | tawn)                           |
|                | Bethesda  | /   | 6 days   | Clea                               | rwate          | r                | 48                                     | X-3         | - 12        |                                 |
| 1              | U. NAME OF HOSPITAL (   | if not in hospital, give streed I Hospital                  | t address)   | d. STREET 608 1                    |                | a Ave            |  |             | 0           | RESIDENCE<br>ON A FARM?<br>S NO |
| 3. 1           | NAME OF<br>DECEASED   | First   | Middle   | Lo                                 | asl            | 4. DATE<br>OF    | Man                                    | th          | Day         | Year                            |
| (              | Type ar print)  | Louis   | Francis  | THIB                               | AULT           | DEATH            | Septen                                 | nber        | 16          | 1959                            |
| 5. S           | EX 6.   | COLOR OR RACE 7. MA   | RRIED NEVER MARRIED  | B. DATE OF BIR                     | тн             | 9                | AGE (In years<br>last birthday)        | IF UNDER 1  |             | INDER 24 HRS                    |
| _              | Male Ca   | eucasian WIDOV  | VED DIVORCED | 8-28                               |                | or foreign cou   | 74 yrs.                                |             |             | AT COUNTRY                      |
|                | during mast of working Mariner                                      | life, even if retired)                                      | U. S. Navy   |                                    |                | ticut            | ,                                      |             | .S.A        |                                 |
| 13.            | FATHER'S NAME   |   | - 83   | 14. MOTHER                         | S MAIDEN N     | IAME             |  |             |             |                                 |
|                | Nelson J.   | THIBAULT  |  | Mar                                | y DEM          | PSEY             |  |             |             |                                 |
| 15. 1<br>(Yes. | no, or unknown)   (If ye  | U. S. ARMED FORCES? 16<br>is, give war or dates of service) |  | INFORMANT                          | 77             | 7 5              | Add                                    |             |             | - 110                           |
| _              |   | VI & II   |  | wimrs.                             | Haze           | I P.             | Thibau.                                | Lt, s       |             |                                 |
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|                | IM  | MEDIATE CAUSE (a)   | remona, o  | roucho                             | genne          | i, wu            | a mesas                                | rases       | . 6         | mo.                             |
|                | 162,1   | DUE TO  |  | 0                                  |                |                  |  |             |             |                                 |
|                | Canditians, if any,   |   | Y 4  | 2. 31                              |                |                  |  |             |             |                                 |
|                | gave rise to immo   |   | 200  | Too                                |                |                  |  |             |             |                                 |
|                | lying cause last.   | (c)   |  |                                    |                |                  |  |             |             |                                 |
| CATION         | PART II. OTHER  | SIGNIFICANT CONDITIONS                                      | CONTRIBUTING TO DEATH BU   | T NOT RELATED T                    | O THE TERMI    | NAL DISEASE      | CONDITION GIV                          | EN IN PART  | PE          | AS AUTOPSY<br>ERFORMED?         |
| CERTIN         | 20a. ACCIDENT WAS U<br>OR CONTRIBUTING []<br>(IF EITHER, NOTIFY MEE | NDERLYING 20b. DE   | SCRIBE HOW INJURY OCCURRE  | D. (Enter nature                   | af injury in F | Part I ar Part   | Il of item 18.)                        |             |             |                                 |
|                |   |   |  | A CE OF INHURY                     | 111 6          | 200 100          |  |             |             | 10                              |
| MEDICAL        | 20c. TIME OF INJURY :   | Whil  | f.   | ACE OF INJURY actory, street, affi | ce bldg., etc. | )   20r. (City ( | or town)                               | (C          | aunty)      | (State                          |
| 7              | p. m.   | 19 at w   | ark at wark  |                                    |                |                  |  |             |             |                                 |
|                | 21. I certify that  | I attended the deced  | ised from Sept. 1  | 0 , 19 5                           | 9, to S        | ept.             | 16, 159,                               | that I los  | st saw th   | e deceose                       |
|                | olive on Sept.  | . 16 , 19   | 59, and that deat  | occurred a                         | 640P           | M, from t        | he causes on                           | d on the    | date sto    | ted obave                       |
|                | MY  | . 1   | // n   |                                    |                |                  | eet, city ar tawn,                     |             |             | DATE SIGNE                      |
|                | ACTUAL SIGNATURE  | reuces to   | me han h   | MD U                               | . S.           | Naval            | Hospi                                  | tal         | 9.          | -17-5                           |
|                | JIOITATORE  | 0   |  |                                    |                |                  |  |             |             |                                 |
| _              |   |   | LCDR, MC, US   | N B                                | ethes          | da, M            | aryland                                | ì           |             |                                 |
| 22a.           | BURIAL, CREMATION,  | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY C  | OR CREMATORY                       |                | 22d. LOCATI      | ON (City, tawn,                        | ar county)  |             | (State)                         |
|                | REMOVAL (Specify)   | 9-21-59   | Arlington  | Nation                             | al             | Arli             | ngton                                  | V           | irgi        | nia                             |
| 23.            | FUNERAL DIRECTORYS A  | E I KA AM MIN DAM -   | ADDRESS  |                                    |                | BY REGISTR       |  | STRAR'S SIG | NATURE      |                                 |
| R              | .A. Pumphre   | ey Funeral  | Home, Betheso  | la, Md.                            | DATE           | 0 2 1 '59        | Cal                                    | [Lun 8. 1   | Kinea       |                                 |
|                |   |   |  |                                    | - 05           | -                |  |             |             |                                 |

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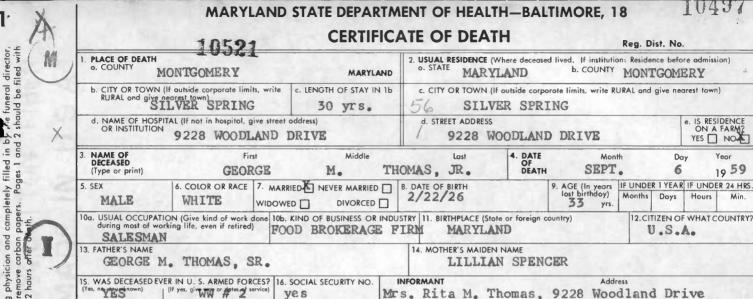
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ATTENDING PHYSICIAN: detached far use by the TO FUNERAL O HOSPITAL page 3 shou

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| alolgulV    |              |   |             | Yalon  |      |



Mrs. Rita M. Thomas, 9228 Woodland Drive ne Personn ves Silver Spring HINTER AL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY LARYNGEAL ABSTRUCTIONS SUDDEN IMMEDIATE CAUSE (o) DUE TO 6ARYNGITIS Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the under-VIRUS INFECTION lying couse lost. CATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY NONE

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town)

20d. INJURY OCCURRED

Not while

While of work of work 1959 ta . 19 5 That I last saw the deceased 

foctory, street, office bldg., etc.)

59, and that death accurred at 4 A.M. fram the causes and an the date stated above. ADDRESS (Street, city or town, stote) ACTUAL 10.011 Ga. Ave., Silver Spring, Md.

HENRY PHYSICIAN'S STOUT NAME (Type)

Doy, Year

22b. DATE THEREOF 220. BURIAL, CREMATION, 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) ST. JOHN'S CATH. CEMETERY MONTGOMERY COUNTY, MARYLAND BURIAL 9/9/59 23. FUNERAL DIRECTOR'S SIGNATURE 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE **ADDRESS** 

WARNER E SILVER SPRING, MD DATE SEP RELEASED

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VS A15 (4) 1SM 9/SB

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VS A15 (4) 15M 9/5B

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH** 

10498 Reg. Dist. No. 215

|   | 10522  | CERTIFICA                    | TE OF DEATH   | 5                               | Reg. Dist. No. 215                                  |
|---|--|------------------------------|---|---------------------------------|---|
| n. PLACE OF DEATH a. COUNTY Montgomer                                     | v  | MARYLAND                     | 2. USUAL RESIDENCE (Whe                                   |                                 | ion: Residence before admission)                    |
| b. CITY OR TOWN (If   | outside corporate limits, write                              | c. LENGTH OF STAY IN 16      | c. CITY OR TOWN (If as                                    | utside carparote limits, write  | RURAL and give nearest tawn)                        |
| RURAL ond give nea<br>Bethesda  | /  | 53 days                      | Arlington   | 8                               | 3 x - 3   |
| d. NAME OF HOSPITA  | L (If not in haspital, give stree                            | et address)                  | d. STREET ADDRESS   |                                 | e. IS RESIDENCE<br>ON A FARM?                       |
| U. S. Nav   | al Hospital  |                              | 6581 N. 2   | 9th Street                      | YES NO NO   |
| 3. NAME OF<br>DECEASED  | First  | Middle                       | Lost  | 4. DATE Mo                      |   |
| (Type or print)   | Axel   | Kolbjorn                     | THOMPSON  | DEATH Sep                       | tember 2 1959                                       |
| 5. SEX  | 6. COLOR OR RACE 7. MA                                       | RRIED NEVER MARRIED B        | . DATE OF BIRTH   | 9. AGE (In years last birthday) | Months Doys Hours Min.                              |
| Male  | Caucasianipov  | WED TO DIVORCED              | 11-5-72   | last birthday)<br>86 yrs        | Months Boys Hoors Mill.                             |
| during mast of working  | (Give kind of work dane 101 ig life, even if retired)        | . KIND OF BUSINESS OR INDUST |   | or foreign country)             | 12. CITIZEN OF WHAT COUNTRY                         |
| Mariner   |  | U.S.A.                       | Norway  |                                 | U.S.A.  |
| 13. FATHER'S NAME   |  |                              | 14. MOTHER'S MAIDEN N                                     |                                 |   |
| Andres T  |  |                              | Dorthea   | (unknown)                       |   |
| 15. WAS DECEASED EVER (Yes, no, or unknown)(If                            | IN U. S. ARMED FORCES? 16 yes, give war or dates of service) |                              | FORMANT   |                                 | dress   |
| yes Bo  | H [Enter anly ane cause per                                  |                              | Hospital Re   | cords                           |   |
| Conditions, if ongove rise to im cause (o), stoting the lying cause last. | mediate (  | tereselva                    | tic hearh   | disease on                      | d delilitation                                      |
| CATIO   | R SIGNIFICANT CONDITIONS                                     |                              |   |                                 | IVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| 20g. ACCIDENT WAS<br>OR CONTRIBUTING [<br>(IF EITHER, NOTIFY N            | UNDERLYING 20b. DE CAUSE OF DEATH LEDICAL EXAMINER           | SCRIBE HOW INJURY OCCURRED   | . (Enter noture of injury in P                            | ort I ar Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.                                | Whi  | for all                      | CE OF INJURY (Home, farm, ory, street, office bldg., etc. |                                 | (County) (State                                     |
| 21. I certify the alive on Sept   |  | 2 1/                         | occurred at 8 P   |                                 |   |
| PHYSICIAN'S NAME (Type)   | P. BAKER,  | LT, MC, USN                  |   | a, Maryland                     |   |
|   | T  | OD NAME OF CONSTRAY OF       | CPEMATORY   | 22d. LOCATION (City, town,      | or county) (State)                                  |
| 220. BURIAL, CREMATION  | , 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR     | CKEMATORT   |                                 | (31016)   |
| Buraal (Specify)  | 9-5-59   | Cedar Hill                   |   | Suitland                        | Maryland  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 110376 CERTIFICATE OF DEATH

Rea Dist No

| 1. PLACE OF DEATH<br>o. COUNTY  | Montgomer   | У                | MARYLAN                          | 2. USUAL RESII<br>o. STATE   | 141             |                     | . If institution in the country    | Residence           | before odm      | (Ission)                               |
|---|---|------------------|----------------------------------|--|-----------------|---------------------|------------------------------------|---------------------|-----------------|--|
| b. CITY OR TOWN RURAL ond give of Rockvill  |   | ls, write        | c. LENGTH OF STAY IN             | 16 c. CITY OR 1  |                 | de corporate lin    |                                    |                     |                 | wn)<br>5x-3                            |
| d. NAME OF HOSPI<br>OR INSTITUTION  | ITAL (If not in hospital, g   |                  | oddress)                         | d. STREET A  | 30              | outh Vi             |                                    |                     |                 | RESIDENCE<br>A FARM?                   |
| Waver   | Ly Sanitari   | nm.              |                                  | 1 3/9/0/5/17   | 11e/Pi/         | dd Mhyre,           | 1.67/9                             | (Arrie)             | YES             | _ NO _                                 |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | Fin<br>Vivia  |                  | Middle<br>Stanley                | Thor   |                 | DATE<br>OF<br>DEATH | Mon<br>Sep                         |                     | 21 <sub>1</sub> | Yeor<br>1959                           |
| 5. SEX  | 6. COLOR OR RACE White  | 7. MARR          | DIVORCED                         |  |                 | 9. AG<br>lost       | E (In years<br>t birthday)<br>yrs. |                     | Days Hou        |  |
| 100. USUAL OCCUPATI   | ION (Give kind of work orking life, even if retired)                                      | done 10b.        | KIND OF BUSINESS OR II           |  | ACE (Stote or f | oreign country)     |                                    | 12. CITI            | ZEN OF WH       | AT COUNTRY                             |
| 13. FATHER'S NAME   |   |                  |                                  | 14. MOTHER'S   | MAIDEN NAM      | E                   |                                    |                     |                 |  |
| William   | Stanley   |                  |                                  | Un   | known           |                     |                                    |                     |                 |  |
| (Yes, no, or unknown)   | ER IN U. S. ARMED FOR<br>(If yes, give wor or dotes of it<br>NO<br>ATH [Enter only one co | Ivice)           | one                              | Mrs Marjor   | ie V.Fr         | ranklan             | d, Was                             | 5-29t               | h.,St.          |  |
| PART I. DE  | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o  DUE TO  ony, which (b) immediate (DUE TO           | 5                | ingestive                        | & Hear   | mia<br>t Za     | rlure               |                                    |                     | ONSET AN        | 3d.                                    |
| couse (o), stoling lying couse lost.  PART II. OT   | the <u>under:</u>   | )                | My CONTRIBUTING TO DEATH         | BUT NOT RELATED TO   | THE TERMINAL    | L DISEASE CON       | DITION GIV                         | EN IN PART          | I(o) 19. WA     | S AUTOPSY FORMED?                      |
| PART II. OT  200. ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF)  20c. TIME OF INJU Hour o. m. |   |                  | Not while                        | URRED. (Enter nature of<br>e. PLACE OF INJURY (<br>foctory, street, office | Home, form,     |                     |                                    | {Co                 | YES             | NO (Stote)                             |
|   | that I attended the 3-23-   | decease<br>, 19) | ed fram. 5-9                     | eath accurred at   | SO US           |                     | causes a ityror town,              | nd an th            | e date sta      | ne decease<br>ated above<br>DATE SIGNE |
| 220. BURIAL, CREMATING REMOVAL (Specify   | ON, 22b. DATE THEREO  |                  | 22c. NAME OF CEMETER Fort Lincol | RY OR CREMATORY  | 220             | d. LOCATION (       | City, town, o                      | or county)          | (S              | tote)                                  |
| 23. FUNERAL DIRECTO   | R'S SIGNATURE   | Has              | ADDRESS 51.03 Wis                | D.C  | 240. REC'D B'   | Y REGISTRAR         | 24b. REGIS                         | otrar's signifung & | NATURE          | J. e                                   |

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To make the body the difficient has been signed by the attending physician and completely filled in the funeral director.

To make the body the certificate has been signed by the attending physician and completely filled in the funeral director.

To make the body the design of the body the principle of the places of the body the filled in the ofter death, Page 4 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 havry

## MARYLAND STATE DEPARTMENT OF REALTH BALTIMORE, 18

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### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10501

CERTIFICATE OF DEATH 10524 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MONTGOMERY MARYLAND MONTGOMERY MARYLAND b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) RURAL and give nearest tawn) SILVER SPRING SILVER SPRING VIS. d. NAME OF HOSPITAL (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? STONINGTON ROAD 516 STONINGTON ROAD YES NO NAME OF Middle 4. DATE First Month Year DECEASED 1959 SEPT. BERTHA MARTE TROUTNER DEATH (Type ar print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 5. SEX lost birthday) Months 2/18/86 FEMALE WHITE WIDOWED TI DIVORCED [ YES. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) Illinois U.S.A. Own home Homemaker FATHER'S NAME 14. MOTHER'S MAIDEN NAME THOMAS BRYAN JOHANNA REITCHE WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Mrs. Eugene C. Spangler, 516 Stonington Rd. INFORMANT NONE NO Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: moute IMMEDIATE CAUSE (a DUF TO Canditians, if any, which gave rise to immediate DUF TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(13) 19. WAS AUTOPSY PERFORMED? YES NO P 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth. 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) While Haur a. m. Nat while at wark at work p. m 21. I certify that I attended the deceased fram 19-1, that I last saw the deceased and that death accurred at 750 P.M. from the causes and an the date stated above. ADDRESS (Street, city ar tawn, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S DONALD NELSON NAME (Type) 22b. DATE THEREOF 22a. BURIAL, CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, tawn, or county) REMOVAL (Specify) Meadow Ridge Mem. Park Cemetery, Elkridge, Maryland 9/30/59 BURIAL 24b. REGISTRAR'S SIGNATURE SILVER SPRING, MD. 24a, REC'D BY REGISTRAR INC. Orthur & Kraus DATE SEP 3 0 '59

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| Poge ed with   | 1. PLACE OF DEATH D. COUNTY MONTGOMERY  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) O. STATE District of Columbia  |
| ± 70 ±   | MONTGOMERY  District of Columbia  b. CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |
| leat<br>leat   | RURAL and give nearest town)   |
| full and   | Bethesda (Rural) 29 days Washington $47 \times 3$  |
| \$ 051   | d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
| Py Py  | U.S. Naval Hospital, Bethesda, Md. 1315 Pennsylvania S.E.  |
| od in an   | 3. NAME OF DECEASED First Middle Last 4. DATE Month Day Year OF  |
| n 24   | (Type or print) William Henry TURK DEATH September 24 1959   |
| Pag Pag  | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR IF UNDER 24 HR.   |
| S. See d   | Male White WIDOWED DIVORCED 7-15-86 73 yrs. Months Days Hours Min.   |
| amp<br>ape   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)   |
| o o o o o o o o o o o o o o o o o o o  | (U.S. Navy)Did not work after retired Michigan U.S.  |
| be an arriva   | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME   |
| ate cioin  | Allen TURK Ada MATHEWS   |
| physic physic hours  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address   |
| D D D D D D D D D D D D D D D D D D D  | Yes   (If yes, give wor or dates of service)   VW I   (Wife) Cora Turk   Same as #2  |
| ath<br>ndin<br>nin   | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  |
| ple ple  | PART I. DEATH WAS CAUSED BY:   |
| the hen  | 150 X DUE TO 1 100 C   |
| that by t  | 2 0000   |
| ed ed an   | gave rise to immediate (b) Susmous (l) (arcinomy & year  |
| gui<br>d in  | cause (o), stoting the <u>under-</u> lying couse last.   |
| ciar<br>ciar<br>ansi   | Z SUPER CONTROL CONTRO |
| s be lay is per lay is be lay in the lay in the lay is be lay in the la | PART II. O'REK SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (Ig)  PERFORMED?  YES X NO C   |
| The gg P purio   | 200 ACCIDENT WAS INDEDIVING TO 200 DESCRIBE HOW INTRIBY OCCURRED (February of injury in Part Lor Part II of item 18.)  |
| tendin<br>ificate<br>the b   | GR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |
| r at r at cert cert ian tian   | 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Hour o. m.  p. m.  19  20e. PLACE OF INJURY (Home, farm, 20f. (City ar tawn) (Caunty) (State factory, street, office bldg., etc.)  |
| PH)  | While Not while at work at work at work  |
| Spite or to con con con con con con con con con co   | 21. I certify that I attended the deceased fram 26 August, 19 59, to 24 Sept., 1959, that I last saw the decease   |
| Aff<br>Aff<br>Affi<br>rial   | alive an 24 September, 19 59, and that death accurred a6: 32PM, from the causes and an the date stated above   |
| TEN<br>the<br>OR:  | ADDRESS (Street, city or town, state)  DATE SIGNE  |
| A CO   | SIGNATURE Douglas R. Koth M.D. U.S. Naval Hospital, Bethesda Md.   |
| o d d o d  | signature 10 1 Roug M.D. U.S. Wavar hospital, be the saa Ma.   |
| RAL shoul  | PHYSICIAN'S Douglas R. KOTH LT MC USN U.S. Naval Hospital, Bethesda Md.  |
| OSF<br>JNE<br>JNE<br>JNE   | 220. BURIAL, CREMATION, PEMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)   |
| may of FL  | Burlai 9-28-59 Amlington National Arlington Virginia   |
| FF   | 23. FUNERAL DIRECTOR'S SIGNATURE 240. REC'D 8Y REGISTRAR'S SIGNATURE 240. REC'D 8Y REGISTRAR'S SIGNATURE   |
| VS A1S (4)<br>1SM 9/S8   | W.W. CHAMBERS 517 11th St. S.E. Washington D.C.  |

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### **CERTIFICATE OF DEATH**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10503

Reg. Dist. No.

| 1. PLACE OF DEATH q. COUNTY Montgomer      | y  | MARYLAN                   | a. STATE              | residence (w      | here deceased  | b. SUNTY                        | an: Residence |             | Imissian)              |
|--|--|---------------------------|-----------------------|-------------------|--|---------------------------------|---------------|-------------|------------------------|
| b. CITY OR TOWN (I                         | If autside carporate limits, write                           |                           |                       |                   |  | ate limits, write R             | URAL and gi   | ive nearest | town)                  |
| Bethesda                                   | (Rural)  | 10 hours                  | Lex                   | cington           | Pa rk  |                                 | 18 X          | - 2-        |                        |
| d. NAME OF HOSPIT                          | AL (If not in hospital, give stre                            | et address)               |                       | ET ADDRESS        |  |                                 |               |             | RESIDENCE<br>N A FARM? |
| U.S. Naval                                 | Hospital, Beth   | esda 14, Md.              | 64                    | 5 Chinl           | ee Dri   | ve                              |               |             | S NO                   |
| 3. NAME OF<br>DECEASED                     | First  | Middle                    | E Constitution of the | Last              | 4. DATE  | Mar                             | nth           | Day         | Year                   |
| (Type ar print)                            | Timothy  |                           |                       | JCHN              | DEATH  | Septe                           | mber          | 5           | 19 5 0                 |
| S. SEX                                     | 6. COLOR OR RACE 7. MA                                       | ARRIED NEVER MARRIED      | 8. DATE OF            | BIRTH             |  | 9. AGE (In years last birthday) |               |             | INDER 24 HRS           |
| Male                                       | Caucasian WIDO   | WED DIVORCED              | Augus                 | 19,1              | 959  | yrs.                            | 1             | Days Ha     | Urs Will.              |
| 10a. USUAL OCCUPATIO                       | ON (Give kind af wark dane 10<br>king life, even if retired) | b. KIND OF BUSINESS OR IN | DUSTRY 11. 8IR        | HPLACE (State     | ar fareign ca  | ountry)                         | 12. CITIZ     | EN OF WH    | AT COUNTRY             |
| None                                       | king me, even in temedy                                      |                           |                       | Maryla            | nd   |                                 | T             | S.A.        |                        |
| 13. FATHER'S NAME                          |  |                           | 14. MOTH              | ER'S MAIDEN I     | NAME   |                                 |               |             |                        |
| George F.                                  | VAUCHAN  |                           | Lois                  | CONTR             | ELL  |                                 |               |             |                        |
| 15. WAS DECEASED EVE                       | R IN U. S. ARMED FORCES?                                     | 6. SOCIAL SECURITY NO.    | INFORMANT             |                   |  | Add                             | ress          |             |                        |
| No.  | (If yes, give war ar dates of service)                       | None (                    | Father)               | George            | F. VA  | UCHAN (S                        | ame as        | #2)         |                        |
| 18. CAUSE OF DEA                           | ATH   Enter only one cause per                               |                           | 1 /                   | 1                 |  |                                 |               | INTERVA     | L BETWEEN              |
| PART 1. DEA                                | TH WAS CAUSED 8Y:  | Heart                     | - /                   | ilu               | 40   |                                 |               | ONSET       | AND DEATH              |
| 0821                                       | IMMEDIATE CAUSE (a)  | 1 1                       | 10                    | a m               | 19   | 2                               | 1             |             |                        |
| Canditians, if a                           |  | Philas                    | 1                     | 11.0/             | .Lan   | 2001                            | . 1           |             |                        |
| gave rise to i                             |  | 211000                    | 7                     | unu               | 2001   | min                             | V 4           |             |                        |
| lying cause last.                          | the under-   | 0                         | 0                     |                   |  |                                 |               |             |                        |
|  | HER SIGNIFICANT CONDITION                                    | S CONTRIBUTING TO DEATH   | BUT NOT RELATE        | D TO/THE TERM     | INAL DISEASE   | CONDITION GIV                   | VEN IN PART   | 1(a) 19. W  | AS AUTOPSY             |
| ATIO                                       | Aseph  | E men                     | 11.11.1               | 45                |  |                                 |               | PE          | REFORMED?              |
| PART II. OTH                               | AS UNDERLYING   20b. D                                       | ESCRIBE HOW INJURY OCCU   | RRED. (Enrey natu     | re of injury in   | Part I ar Part                                       | II of item 18.)                 |               |             |                        |
| OR CONTRIBUTING                            | MEDICAL EXAMINER)  |                           |                       |                   |  |                                 |               |             |                        |
|  | Y Manth, Day, Year 20d                                       | . INJURY OCCURRED 20e.    | PLACE OF INJU         | RY (Hame, farr    | m, 20f. (City  | ar tawn)                        | (C            | ounty)      | (State                 |
| 20c. TIME OF INJUR<br>Haur a. m.<br>p. m.  | Wh   | ile Nat while             | factory, street, o    | office bldg., etc | c.)  |                                 |               |             |                        |
|  |  |                           | show                  | 50 . 5            | Santani  | ham 50                          |               |             |                        |
|  | nat I attended the dece                                      |                           |                       |                   |  |                                 |               |             |                        |
| alive on 5 Sc                              | eptember , 19  | 59 , and that de          | ath accurred          | at U:2U           |  |                                 |               |             | ated abave             |
| ACTUAL                                     | 41/13 /  | Sunda                     | 11 0                  | 37- 1- 9          |  | reet, city ar tawn,             |               |             |                        |
| SIGNATURE                                  | NFOS IV  | very                      | M.D. U.S.             | Naval             | Hospi.   | tal, Bet                        | nesda,        | Md.         | 9-5-59                 |
| PHYSICIAN'S                                | TO ATTENDED TO   | NO TION                   |                       |                   |  |                                 |               |             |                        |
| NAME (Type)                                | B. AVERY, LI   | MC USN                    | u.s.                  | Naval             |  | tal, Bet                        |               | _Md         |                        |
| 22a. BURIAL, CREMATIC<br>REMOVAL (Specify) |  | 22c. NAME OF CEMETER      | Y OR CREMATOR         | Y                 | 22d. LOCAT   | ION (City, tawn,                | ar caunty)    | 4000        | (State)                |
| Burial                                     | 9-9-59   | Arlington Na              | tiona 1               |                   |  |                                 | David Control |             | inia                   |
| DUVUTUUL GAL                               | 'S SIGNATURE May   | ADDRESS                   |                       |                   | 'D'BY REGISTI  |                                 | STRAR'S SIG   | NATURE      |                        |
| PUMPHREY FU                                | NERAL HOME, 82   | 34 Georgia Ave            | e., Silv              | er Spri           | ngs, M   | d.                              | -0.0          | - 8 4       | ,                      |
|  |  |                           |                       |                   | March 12 14 7 15 15 15 15 15 15 15 15 15 15 15 15 15 | 9 73                            | AALLINA       | 1 A. 141    | PVVV                   |

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campletely filled in by the fun papers. Pages 1 and 2 should

the attending physician page 3 should be detached far use as the burial-transit permit. Then pleose remave co the registrar prior to buriol, crematian, ar remaval, and in any event within 72 haurs of

ETOR: After this certificate has been signed by

TENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours

TO HOSPITAL OF may be retaine VS A15 (4) 1SM 9/58 STATE OF STREET, STATE OF STATE

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| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | } |
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CEDTICICATE OF DEATH

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|  | THE PIKE   |  | LICITION   |                                    |                     | R                  | eg. Dist. No   |                          |
|--|--|--|--|------------------------------------|---------------------|--------------------|----------------|--------------------------|
| PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (Where          | deceased lived.     | If institution:    | Residence befo | ore admissian)           |
| o. COUNTY  | ontagmay   | 1.5  | MARYLAND   | Waruland                           | t                   | . COUNTOR          | NRE            | GEO.                     |
| b. CITY OR TOWN  | (If autside arparate limit                                 |  | OF STAY IN 16  | c. CITY OR TOWN (If outs           | ide carporate lin   | nits, write RUR    | AL ond give ne | arest tawn)              |
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| d. NAME OF HOSE  | PITAL (If nat in haspital, g                               | ive street oddress)  |  | d. STREET ADDRESS                  | SVIIIE              | /                  | 0/0-           | e. IS RESIDENC           |
| OR INSTITUTION   | P  | . 40 li  | 3 xp Xas   | 0110 14                            | the A.              | -0                 |                | ON A FARM                |
| vas hura 15  | n Santary  | use w  | -  | 8118 - 17                          | 7 (3)               | (C)                |                |                          |
| NAME OF DECEASED   | 2/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1                    | ol wor   | Middle   | Lost 4                             | OF .                | Month              | Do             |                          |
| (Type ar print)  | MINGIA   | 7 1-111  | NOIS   | Doll war A                         | PEATH               | 9                  |                | 9 195                    |
| . SEX  | 6. COLOR OR RACE   | 7. MARRIED   NEV   |  | B. DATE OF BIRTH                   | 9. AG               |                    | anths Days     | Hours Mir                |
| Male   | white  |  | DIVORCED [   | 9-18-59                            |                     | yrs.               |                | 14 15                    |
| <ul> <li>USUAL OCCUPAT<br/>during mast af we</li> </ul>      | ION (Give kind of work or<br>trking life, even if retired) | done 10b. KIND OF BU   | ISINESS OR INDUS   | STRY 11. BIRTHPLACE (State or      | foreign country)    |                    | 12. CITIZEN O  | F WHAT COUNT             |
| IN.  | FANT   | N  | ONE  | Takona Par                         | 15. W               | avy land           | 6              | ISA                      |
| . FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NA             |                     | 1.                 |                |                          |
| win Illiu  | F. Voll  | Mev.   |  | AnneWa X                           | QVQSA.              | Worr               | 2)             |                          |
|  | ER IN U. S. ARMED FOR                                      |  | URITY NO.  | NFORMANT                           | 77232               | Address            |                |                          |
| NO, or unknown)  | (If yes, give wor or dates of se                           | NO   | NE 13  | rosp Wal Ro                        | 2 hier              |                    |                |                          |
| TIR CAUSE OF D   | EATH [Enter anly ane car                                   | use per line for (a) (b)   |  | asp wat it                         | Ceros.              |                    | INT            | ERVAL BETWEEN            |
|  | ATH WAS CAUSED BY:   | H1/  | NYIM   |                                    |                     |                    | ON             | SET AND DEAT             |
|  | IMMEDIATE CAUSE (o)  |  | 21/11  |                                    |                     |                    |                |                          |
| 762,0  | DUE TO   | 1. 1   | not.   | 101                                |                     |                    |                |                          |
| Canditians, if   |  | muce   | nerso  | unka                               |                     |                    |                |                          |
| cause (a), statin  |  |  |  |                                    |                     |                    |                |                          |
| lying cause last   | _ / (c)  |  |  |                                    |                     |                    |                |                          |
| PART II. O   | THER SIGNIFICANT CON                                       | DITIONS CONTRIBUTION   | IG TO DEATH BUT  | NOT RELATED TO THE TERMINA         | L DISEASE CON       | DITION GIVEN       | IN PART 1(a)   | 19. WAS AUTOP PERFORMED? |
| <u> </u>   |  |  |  |                                    |                     |                    |                | YES NO                   |
| PART II. O  20g. ACCIDENT V OR CONTRIBUTIN (IF EITHER, NOTIF | VAS UNDERLYING I   | 20b. DESCRIBE HOW  | INJURY OCCURRE   | D. (Enter noture of injury in Por  | t I or Part II of i | tem 1B.)           |                |                          |
|  | Y MEDICAL EXAMINER)  |  |  |                                    |                     |                    |                |                          |
| 20c. TIME OF INJU  |  | ar 20d. INJURY OCCL  | JRRED 20e. PL  | ACE OF INJURY (Home, form,         | 20f. (City or taw   | vn)                | (Caunty)       | (Sto                     |
| Hour o.m.  |  | While Not who twork of work  |  | ctary, street, office bldg., etc.) |                     |                    |                |                          |
|  |  |  |  |                                    |                     |                    |                |                          |
| 21. I certify  | hat I attended the   |  |  | , 19, ta                           |                     |                    |                |                          |
| 1  |  | _, 19, a   | nd that death  | accurred atM                       |                     |                    |                |                          |
| alive an   |  |  |  |                                    |                     |                    | te)            | DATE SIGN                |
| 9/   | 111111   | Alexa as   | - Mil  | 722 0                              | DRESS (Street, ci   | ly or town, sta    |                | AL. I                    |
| alive an   | mes RC   | oleman   | n MID  | M.D. 733 52                        | IGO A               | VE.                |                | 9/20/                    |
| ACTUAL   | mis RC   | oleman   | n MID  | M.D. 735 SC                        | 160 A               | V6.                |                | 9/20/                    |
| 9/   | TANES A  | oleman<br>COLEMA   | n MLD  | 4.0. 733 SC                        | 160 A               | V6.                |                | 9/20/                    |
| ACTUAL<br>SIGNATURE<br>PHYSICIAN'S<br>NAME (Type)            | THMES A  | oleman<br>COLEMA<br>F 22c. NAME  | MAN MAN E OF SEMELERY O  | 41LVE                              | 160 A               | VE.                | Md.            | 9/20/                    |
| ACTUAL<br>SIGNATURE<br>PHYSICIAN'S<br>NAME (Type)            | THMES A ON. 22b. DATE THEREO                               | COLEMAN<br>COLEMAN<br>F. g 22c. NAME   | NEW SERVERY OF   | 41LVE                              | 160 A<br>2 5PA      | VE.                | Md.            | 9/20/                    |
| ACTUAL<br>SIGNATURE<br>PHYSICIAN'S                           | W 1/21/3   | Oleman<br>COLEMIT<br>OF 22c. NAME<br>ADDRE   | W SEMESTERY OF SEM | R CREMATORY 22                     | L SPA               | City, togh, are    | Md.            | 1000                     |
| ACTUAL<br>SIGNATURE<br>PHYSICIAN'S<br>NAME (Type)            | W 1/21/3   | oleman<br>Colt Mit<br>Per 22c. NAME<br>S 9 22c. NAME<br>S 9 22c. NAME<br>S 9 22c. NAME | THE SET OF SEMESTERY OF SEMESTE | R CREMATORY 22                     | L SPA               | City, togin, ar of | Md.            | JRE .                    |

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VS A15 (4) 15M 9/58

registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10596

10527 Reg. Dist. No 1. PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland o. COUNTY b. COUNTY MARYLAND Montgomery Montgomery b. CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Chevy Chase years Chevy Chase d. NAME OF HOSPITAL (If not in hospital, give street address) H. STREET ADDRESS ON A FARM? Springfield Drive 6000 Springfield Drive YES NO TO NAME OF 4. DATE Middle Month Yeor DECEASED 19 59 26. **ISABEL** GRAFF WALTEN DEATH Sept. (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF SIRTH Months Days White Female Oct.12, 1879 WIDOWED DIVORCED T 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? HOUSEWITE even if retired) Washington, D. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Graff Antonie Beneke INFORMANT SOT 16. SOCIAL SECURITY NO. Address 15, WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Dr. Maxmilian G. Walten Same as Item #2 None 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Cerebral Thrombosis davs DUE TO & Cardiac failure 12 days Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour o. m. Not while 19 ot work ot work Sept 1959 that I last saw the deceased 21. I certify that I attended the deceased fram Sept 1959 10 and that death occurred at\_ M, fram the causes and an the date stated above. alive an DATE SIGNED ADDRESS (Street, city or town, stote) ACTUAL 9-26-59 4630 Montgomery Ave., SIGNATURE PHYSICIAN'S ANDREW J. BRENNAN Bethesda, Maryland NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) Entombment Cedar Hill Mausoleum Prince George Co., Md. 23. FUNERAL/DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR Bethesda, Md. DATE SEP 2 9 '59 Orthug & Krans

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VS A15 (4) 1SM 10/57

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

10371

Reg. Dist. No.

10507

|   |               | PLACE OF DEATH  | MARYLAND                   | 2. USUAL RESIDENCE (Where decear          | ed lived. If institution: Residence beb. COUNTY | efare admission)              |
|---|---------------|---|----------------------------|---|---|-------------------------------|
|   | _             | b. CITY OR TOWN (If autside carporate limits, write   | c. LENGTH OF STAY IN 16    | marulant                                  | Howara  |                               |
|   |               | RURAL and give rearest town)  | C. ELINOTT OF STAT IN IB   | c. Citt Ox HOVAN (if Buiside con          | porote limits, write RURAL and give             | negresi tawnj                 |
|   | 1             | aloma farti ma.   | 40045                      | Lauret                                    | 15X-2   |                               |
|   | ы             | d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION                           | address)                   | d. STREET ADDRESS                         |   | e. IS RESIDENCE<br>ON A FARM? |
|   |               | Vashington dan? Hos   | pitol                      | 401 monta                                 | omery St  | YES NO TH                     |
|   |               | NAME OF DECEASED (Type or print)  First   | Middle                     | Lost 4. DATE OF DEAT                      |   | Doy Yeor 2.3 19.29            |
|   | S. 5          | SEX   6. COLOR OR RACE   7. MARS  | /                          | B. DATE OF BIRTH                          | 9. AGE (In years IF UNDER 1 YE                  | AR IF UNDER 24 HRS.           |
|   |               | 7 W WIDOW   |                            | 11-29-96                                  | lost birthdoy) Manths Day                       |                               |
|   | 10a           | . USUAL OCCUPATION (Give kind af work done 10b. during most of working life, even if retired) | KIND OF BUSINESS OR INDUS  | TRY 11. BIRTHPLACE (State or foreign      | country) 12. CITIZEN                            | OF WHAT COUNTRY?              |
|   | . /           | 1 Surt Coinsefor Children   | · Center Lau               | Tennsylvan                                | ie  | 15A                           |
|   | 13.           | FATHER'S NAME   |                            | 14. MOTHER'S MAIDEN NAME                  |   |                               |
|   |               | george Wood   |                            | manie Bi                                  | 9/24  |                               |
|   |               | WAS DECEASED EVER IN U. S. ARMED FORCES? 16.  | SOCIAL SECURITY NO. 17. IF | FORMANT ()                                | Address 33                                      | 1 Lemestas                    |
|   |               | 70  |                            | Patients Cho.                             | + eyes, of                                      | A Parket                      |
|   |               | 18. CAUSE OF DEATH [Enter anly one cause per lin  | ne for (a), (b), and (c).] |   | I do Un   | NTERVAL BETWEEN               |
|   |               | PART 1. DEATH WAS CAUSED BY:  | nTonias Ca                 | an aru Occhusia                           | with mysen dates                                | NSET AND DEATH                |
|   |               | IMMEDIATE CAUSE (o)   | Process Co.                | 20 / Colon                                | John Market                                     | 3 days                        |
|   |               | 400.0 DUE TO ANT  | win en la ali              | alla + Dino                               | 2 - 17  | 151 11                        |
|   |               | Canditians, if any, which gave rise to immediate  | ecci as a comme            | Heart and                                 |   | 1/1/2012                      |
|   |               | cause (a), stating the under-   |                            |   |   |                               |
|   |               | lying cause last. (c)   |                            |   |   |                               |
| Î | Z O           | PART II. OTHER SIGNIFICANT CONDITIONS   | CONTRIBUTING TO DEATH BUT  | NOT RELATED TO THE TERMINAL DISEA         | SE CONDITION GIVEN IN PART 1(a                  | 19. WAS AUTOPSY               |
| ) | AT            | Dealetes m  | ellitus.                   | + Anuria                                  |   | PERFORMED? YES NO NO          |
|   | CERTIFICATION | 200. ACCIDENT WAS UNDERLYING 20b. DESC  | CRIBE HOW INJURY OCCURRED  | . (Enter noture of injury in Port I or Po | ort II af item 18.)                             |                               |
|   |               | (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            |   |   |                               |
|   | S             |   |                            | CE OF INJURY (Home, farm, 20f. (Ci        | ty ar town) (Coun                               | ly) (State)                   |
|   | MEDICAL       | Haur a.m. While at wart   |                            | tary, street, affice bldg., etc.)         |   |                               |
|   |               | 21. I certify that I ottended the decease   | ed from april              | , 1959, to Sant.                          | 23, 1959, that I last                           | sow the deceased              |
|   |               | alive on Sent 23.19   |                            | occurred at 11:50 4M, fro                 | m the course and on the                         | late stated above             |
|   |               |   | , and mar dodin            |   | Street, city or tawn, state)                    | DATE SIGNED                   |
|   |               | ACTUAL AL B   | Munch.                     | SENI Cala                                 | ".00 Pass.                                      | 9/22/50                       |
|   | Н             | SIGNATURE A LASSICE 13  | 1                          | A.D. 02001 9000                           | race of the o                                   |                               |
|   |               | PHYSICIAN'S RUSSELL B.  | Arnold M. D                | , Silver Sour                             | ing, mid  |                               |
|   | 220           | BURIAL, CREMATION, 22b. DATE THEREOF. REMOVAL (Speedby)                                       | 22c. NAME OF CEMETERY OF   | CREMATORY 22d. LOC                        | ATION (City, town, or county)                   | (State)                       |
| ŀ | 23.           | FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS 4                  | 240 PEC'D BY DECL                         | STRAR 246, REGISTRAR'S SIGNAL                   | TIPE :                        |
|   | /             |   | 213 1 11 19                |   | 5 59 Ciriling                                   |                               |
| 1 | 1             | - 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 212 Milestock              | DATE 22                                   | 4   | - CLANCE                      |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 132 DE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10508

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY MONTGOMERY g. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and give nearest lown) THESDA HSHING TON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? SECREIA AVE OSP YES NO NAME OF Middle DATE Month Day Year DECEASED WELBORN (Type or print) SALANNAH DEATH 19.5 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. lost birthday) Months Days Hours WIDOWED 5 DIVORCED | 58 yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 4519 CAROLIDA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address BACTIMORE, Md 647 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), sloting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19, WAS AUTOPSY CERTIFICATION PERFORMED? NO T 20a, EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Port II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stale) Hour factory, street, office bidg., etc.) Not while p. m. at work at work 21. I certify that I took charge of the remains described above, held an Autopsy K. Inspection Inquiry and find that death resulted from: Natural causes Accident . Suicide . Homicide . Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER **EXAMINER'S** NAME (Type) DEPUTY MEDICAL EXAMINER 220 BURIAL, EREMATION, 22d. LOCATIONU(City, town, or equnty) REMOVAL (Specify) 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 2 2 '59 Ciriling & Traus

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10509 MEDICAL EXAMINER'S CERTIFICATE OF DEATH crematian, Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL D c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF DATE First Middle Month Year Last Day DECEASED OF DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER TYPAR IF UNDER 24 HRS. lost birthday) retained 2 with it Months Days Hours WIDOWED [ DIVORCED [ YES. 0 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 3 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) and ofter and pe 1, 2, may 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Pages 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give wor or dates of service) Give PM3 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) alang with far burial-transit DUE TO Conditions, if ony, which gove rise to immediate cause **DUE TO** (o), stoting the underlying couse last. ु Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY SD PERFORMED? used NO X YES | 20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) factory, street, office bldg., etc.) While Not while e. m. p. m. ot work ot work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection Inquiry X. and find that ECTOR: death resulted from: Natural causes X, Accident . Suicide . Undetermined cause Homicide . Ch; MEDICAL DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER forwarded of FUNERAL ASSISTANT MEDICAL EXAMINER DEPUTY **EXAMINER'S** DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) (Stote) REMOVAL (Specify) 0 20.1959 Andrew Chane McLain. Virginia 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Everly Funeral Home Fairfax, Va. VS. A15ME(5) Cultura S. Trava 5M 9/55

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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH 10530 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND Montgomery Pennsvlvania b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) Bethesda 9 days Sidman d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO The Clinical Center. Bethesda ll. Md. Box 9 NAME OF 4. DATE Yeor DECEASED DEATH (Type or print) Ned (none) Westover September 19 59 IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months WIDOWED | DIVORCED [ April 21, 1896 Male 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) unknown Pennsylvania U.S.A. Mechanic & Electrician 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Ruth Thompson
INFORMANT The Medical Record Address John Edwin Westover 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO The Clinical Center, Bethesda 14, Maryland 208-07-0097 Yes INTERVAL BETWEEN
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5 minutes 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: Operative cardiac arrest IMMEDIATE CAUSE (a) DUE TO Acquired calcific aortic stenssis 20 years Canditions, if any, which gove rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES T NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) Hour o. m. While Not while of work of work 21. I certify that I oftended the deceased from September 6, 1959 to September 15, 19 59 hat I last saw the deceased glive on September 15 , and that death occurred all 105 M, from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, stote) 9-15-59 ACTUAL The Clinical Center National Institutes of Health PHYSICIAN'S E. Kent Carney, M.D. NAME (Type) Bethesda ll. Maryland 22d. LOCATION (City, town, or county) 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) EJOHNSTONN BURIAL FOREST-LAWN cem. 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 240 REC'D BY REGISTRAR DATE Cirling & House

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CEPTIFICATE OF DEATH

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|               | b. CITY OR TOWN (I<br>RURAL and give no                   | If outside corporate lim                       | its, write  | c. LENGTH        | OF STAY IN 16      | c. CITY            | OR TOWN               | (If outsi | ide corpor  | ote limits, write F                                   | URAL ond g    | ive nearest | town)   |        |
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|               |   | ry County                                      |             | neral            | Hosp.              | II GI              | anite                 |           |             |   |               |             | :> U    | NO X   |
|               | NAME OF<br>DECEASED<br>(Type or print)                    | Kenneth  |             | Edwar            | Middle             | Wils               | Last                  | 4         | OF<br>DEATH | Mor<br>9  | ith           | Day 6       |         | 9 59   |
|               | SEX   | 6. COLOR OR RACE                               |             |                  |                    |                    |                       |           |             |   | TIE HAIDED    |             |         |        |
|               | ale   | C. COLOR OR RACE                               | WIDOW       |                  | R MARRIED DIVORCED | B. DATE OF         | /59                   |           |             | <ol> <li>AGE (In years lost birthdoy) yrs.</li> </ol> | Months 7      |             | OUTS    | Min.   |
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|               | during most of worl                                       | king life, even if retired                     | )           | 71               | 10-1               |                    |                       |           |             | ,   |               |             |         | .00.11 |
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| 3.            | FATHER'S NAME   | 1 1  | 1           | 1                |                    | 14. MOT            | HER'S MAIDE           | EN NAM    | AE          |   |               |             |         |        |
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| CERTIFICATION | 20a. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES    | CRIBE HOW IN     | NJURY OCCURRE      | D. (Enter nat      | ure of injury         | in Port   | l or Port   | II of item 18.)                                       |               |             |         |        |
| MEDICAL       | 20c. TIME OF INJUR  | Y Month, Day, Ye                               | or 20d. II  | NJURY OCCUR      | RED 20e Pt         | ACE OF INJ         | IRY (Home 1           | form      | 20f (City)  | or town)  | 10            | ounty)      |         | {Stote |
| ă             | Hour o.m.   |  | While       | Not while        |                    | clory, street,     | office bldg.,         | elc.)     | 201. (611)  | o. 10411)   | 10            | ouniy)      |         | faioit |
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|               |   | 9-5-   |             |                  |                    |                    |                       |           |             |   |               |             |         |        |
|               | alive on  | 3-3-   | , 19        | 9, an            | d that death       | occurred           | al 2:3                |           |             | the causes o  |               | e date :    | stated  | d abo  |
|               |   | 1111   | -           | 115              | -                  |                    |                       | ADI       | DRESS (Str  | eet, city or town,                                    | stote)        |             | DAT     | E SIGI |
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|               | PHYSICIAN'S   |  |             |                  |                    |                    |                       |           |             |   |               |             |         |        |
|               | NAME (Type) C   | harles S.                                      | Whi         | taker            | , M.D.             |                    |                       |           |             |   |               |             |         |        |
| 22c           | BURIAL, CREMATIO  | N, 226. DATE THEREC                            | )F          | 22c. NAME        | OF CEMEJERY C      | R GREMATO          | RY                    | 22        | d. LOCATI   | ON (City town   | or countyl"   |             | (Stote) | 7      |
| -             | REMOVAL (Specify)   | 9-7-6  | 54          | At               | White his          | nun                | )                     | 1         | 1/10        | 2010/1  | refe ;        | , 7         | 11      | / , -  |
| 12            | FUNERAL-DIRECTOR  | S SIGNIATURE                                   | 1           | ADDOCC           | - Cog              | 2 4                | 4                     | 1         | 000         |   |               | 1//0        | -4      | -      |
| 3.            | TONCKAL DIRECTOR  | Al Ula   | 6/10        | ADDRES           | 1/2 ://            | 1, 50              |                       |           | Y REGISTR   |   | STRAR'S SIG   | NATURE      |         |        |
| 1             | unio:   | M. Sylle                                       | pert        | 4.4              | nesoll             | 0,14               | DATE                  | SEP       | 9 '59       | a a   | Thun &        | though      |         |        |

moy be retained by the hospitol or ottending physician.

TO FUNERAL DE COR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should a detached for use as the burial-transit permit. Then please remove corbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs VS A15 (4) 1SM 10/57

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#### CERTIFICATE OF DEATH 10372

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|--------------|--|---|--------------------------|
|              | 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (HOME) OF DECEASED                         | 1 /                      |
|              | COUNTY MONTE OMEN; MARYLAND  | STATE District of County                                      | 1013 A                   |
|              | CITY (If outside corporete limits, write RURAL   LENGTH OF STAY  | CITY (If outside corporete limits, write RURAL and give neere | st town)                 |
| 9            | OR end give neerest town) Town Take ma Park 3 mo.  | TOWN Washington   | 20 47x-3                 |
| The state of | HOSPITAL OR 17300 Baltimore Avenus STREET ADRESS Haven Rest Home ore Avenus  | STREET ADDRESS 1541 251th SE.                                 | S, E.                    |
|              | 3. NAME OF (First) (Middle)  OECEASED (Type or Print) Myrtle Margarite WO  | CKLEY DEATH Sept.   | (Dey) (Yeer)<br>6 19 5 9 |
|              | 5. SEX 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF WIDOWED, DIVORCED, USpecify red Deco   | ember 30,189 6/ yrs. Months                                   | Deys Hours Min.          |
| i            | 10e. USUAL OCCUPATION (Give kind of work done during most of working life, eyen if retired)  | 11. BIRTHPLACE (State or foreign country) 12.                 | COUNTRY?                 |
| i            | 13. FATHER'S NAME Dennis Callahan  | 14. MOTHER'S MAIDEN NAME Melvinz Russell                      |                          |
|              | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.   | 17. INFORMANT & ADDRESS                                       |                          |
|              | (Yes, no, or unk.) (If Yes, give war or dates of service)  | Nrs. Nova Seidler, 1609 3                                     | 01/ St.S.E., 20          |
|              | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   | TIFICATION  | ONSET AND DEATH          |
| ŝ            | A 1  | osis, penevalize  | 2.0 yes                  |
|              | ANTECEDENT CAUSE(S) DUE TO   | Thrombosis & Parlyeis   | 10 mo                    |
|              | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  DUE TO  CAUGE  A VOI 20  DISEASES OR CONDITIONS, IF ANY, IN THE TOP TO | ecompensation   | I WK.                    |
| 0            | TO THER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |                          |
|              | 19e. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?             |
|              |  |   | YES NO                   |
|              | 21e. ACCIDENT WAS UNDERLYING 21b. PLACE (Home, ferm, factory, OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc.)  (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21c. WHERE DID INJURY OCCUR? (City or town) (County           | y) (Stete)               |
|              | 21d. TIME OF INJURY (Month) (Day) (Yeer) (Hour) 21e. INJURY OCCURRED While Not while et work et work   | 21f. HOW DID INJURY OCCUR?                                    |                          |
| ì            | 22. I hereby certify that I attended the deceased from   |   |                          |
| 1            | alive on Septi. 5, 19 59 and that death occurred at  | AM, from the causes and on the date stated                    | above.                   |
| 5 10M        | SIGNATURE ALCOST W. Libson M.D. 29   | ADDRESS (Street, city, town, state)                           | DATE SIGNED              |
| 1.5          | 23. BURIAL CREMATION, DATE THEREOF NAME OF CEMETERY OR   | CREMATORY LOCATION (City, town, or county)                    | (Stete)                  |
| A15C         | Buremark (SPECIFY) 9-10-59 Arlingto  | on mational   Ft Myer, Va.                                    |                          |
| VS           | 24. REC'D BY REGISTRAR   REGISTRAR'S SIGNATURE   |   | DDRESS                   |
|              | SEP 8 '59 Crither & Krous  | Lee Funeral Home - Wash                                       | D a                      |
|              | UNIT.  | 1 DEC THIETEL HOME - MSSN                                     |                          |

### 10372 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

| BI 3NOMITABLE  | BIT OF HEALTH   | E DEPARTM   | ATE CHARTS.                           |                  |               |
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10373 Rog. Dist. No. 10516 CERTIFICATE OF DEATH eral directar, be filed with 1. PLACE OF DEATH MONTGOMERY With 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence befare admission) b. COUNTY Maryland Montgomery MARYLAND 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 Takoma Park Takoma Park pla d. STREET ADDRESS . IS RESIDENCE d. NAME OF HOSPITAL (If not in hospital, give street oddress) ON A FARM? 910 Kennebec Street 22 910 Kennebec Street YES NO and c 4. DATE Day NAME OF Middle Year OF DEATH DECEASED Wood Katie May 19 (Type or print) 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 5. SEX 22/1866 Months Days Hours Min. female white DIVORCED T WIDOWED TO papers. campl 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stote or fareign country)

Michigan 12. CITIZEN OF WHAT COUNTRY? costb U.S.A. pup carbon 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ofter physician Julia Robinson Hiram Barnes 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Old Court House Road A. Wood George no no New Hyde Park, L.I.N INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one couse per line far (o), (b), and (c).] PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO E. SUN Conditions, if ony, which gove rise to immediate DUE TO Pe couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO TO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I ar Port II of item 18.) 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) 20c. TIME OF INJURY 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Hour o. m While Not while of work at work p. m. 19\_51, that I last saw the deceased 21. I certify that I attended the deceased from and that death occurred M. from the causes and on the dote stated above. olive on ADDRESS (Streets city or town, Istate) DATE SIGNED ACTUAL William FUNERAL POGE 3 should PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, tawn, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) BEHOVA Topecify) Washington, D.C. Glenwood Ceme tery 0 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 2901 With S The S.H. Hines VS A15 (4) DATE SEP 2 2 '59

death. Page

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MARYLAND STATE DEPARTMENT OF HEALTH -BALTIMONE,

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CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY O STATE b. COUNTY MARYLAND Montgomery b. CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 RURAL and give nearest town) Washington. D.C. Kensington d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION e. IS RESIDENCE ON A FARM? Kensington Gardens Nursing 31-15th Street N.E. Home. YES NO NAME OF Middle Month Year DECEASED Sept. 14th.1959 NORA Wood (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH lost birthdoy) Dovs White Female WIDOWED TX DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A. Washington, Pa. Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Agnes Miller William Hogue 15. WAS DECEASED EVER IN U. S. ARMED FORCES? INFORMANT Address 16 SOCIAL SECURITY NO Miss Lulu Hogue 31-15th St. N.E. 390-106-P 1B. CAUSE OF DEATH [Enter only one couse per line or (o), (b), and (b) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT MATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) MEDI Hour o. m While Not while ot work of Werk 9, 19\_\_,that I last saw the deceased I attended the deceased frame 21. I certify that alive an and that death occurred at M. from the causes and an the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) Cedar Hill Cem. Suitland, Md.

24g. REC'D BY REGISTRAR

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24b. REGISTRAR'S SIGNATURE

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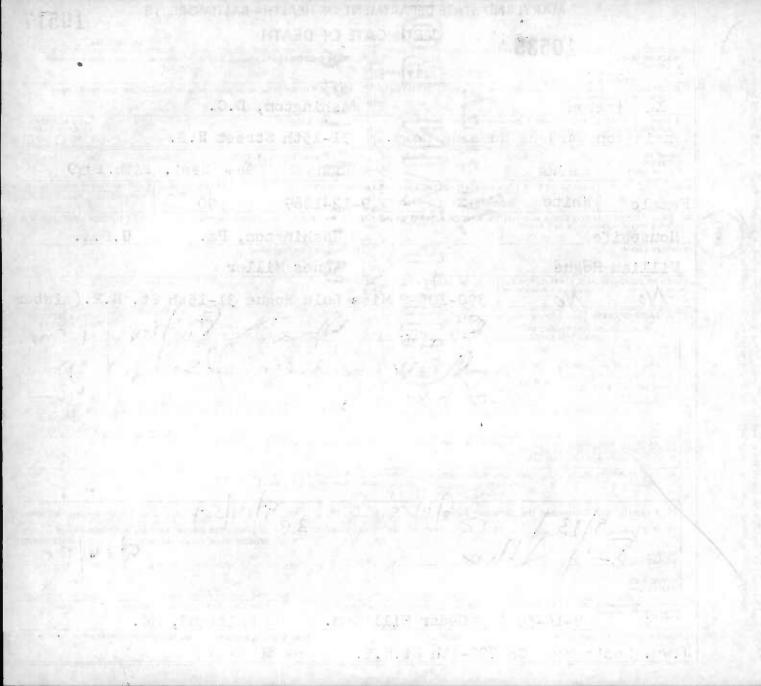
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VS A1S (4) 15M 9/58 23. FUNERAL DIRECTOR'S SIGNATURE

.Wm. Lee's Sons Co 300-4th St.N.E.



TO HOSPITAL OR TO FUNERAL D

VS A15 (4) 15M 10/57

10518

10536

**CERTIFICATE OF DEATH** 

Reg. Dist. No.

| -        |   |                         |                        |          |   |                   |                                |              |                |                        |
|----------|---|-------------------------|------------------------|----------|---|-------------------|--------------------------------|--------------|----------------|------------------------|
| 1.       | PLACE OF DEATH OCCUPITY Montgomery  |                         | MARYLAN                | - 11     | USUAL RESIDENCE (W<br>C. STATE<br>Florida           | here deceased I   | ived. If institution b. COUNTY | n: Residence | e before adn   | nissian)               |
|          | <ul> <li>CITY OR TOWN (If outside carpord<br/>RURAL and give nearest town)</li> </ul>         | ate limits, write       | c. LENGTH OF STAY IN   | 1Ь       | c. CITY OR TOWN (If                                 | autside carpora   | te limits, write R             | JRAL and gi  | ive nearest to | own)                   |
|          | Bethesda  |                         | 35 days                |          | Fort Piero  | 08                | 48                             | x-3          |                |                        |
|          | d. NAME OF HOSPITAL (If not in has OR INSTITUTION   | pitol, give street      | oddress)               |          | d. STREET ADDRESS                                   |                   |                                |              |                | RESIDENCE<br>N A FARM? |
| L        | The Clinical Cen  | ter, Bet                | hesda ll. Md           | l.       | 104 Indian  | n Hills           | Drive                          |              |                | □ NO 🗖                 |
| 3.       | NAME OF<br>DECEASED   | First                   | Middle                 |          | Lost  | 4. DATE<br>OF     | Man                            | th           | Day            | Year                   |
|          |   | Vickie                  | Diane                  |          | Young   | DEATH             | Septe                          | ember        | 27,            | 1959                   |
| 5.       | SEX 6. COLOR OR   | RACE 7. MAR             | RIED NEVER MARRIED     | B.       | DATE OF BIRTH                                       | 44                | AGE (In years last birthdoy)   |              |                | NDER 24 HRS.           |
|          | Female White  | WIDOW                   | ED DIVORCED            | וכ       | May 1, 19   | 954               | yrs.                           | Months [     | Doys Hau       | rs Min.                |
| 100      | . USUAL OCCUPATION (Give kind of during most of working life, even if                         | work dane 10b.          | KIND OF BUSINESS OR IN | NDUSTR   | Y 11. BIRTHPLACE (State                             | ar foreign cou    | ntry)                          | 12. CITI2    | ZEN OF WH      | IAT COUNTRY            |
|          | Child   | renrea)                 | None                   |          | Georg   | gia               |                                |              | U. S.          | A.                     |
| 13.      | FATHER'S NAME   |                         |                        |          | 14. MOTHER'S MAIDEN                                 |                   |                                |              |                |                        |
|          | John H. Young   |                         |                        |          | Glady   | ys Elle           | r                              |              |                |                        |
| 15.      | WAS DECEASED EVER IN U. S. ARME   | D FORCES? 16.           | SOCIAL SECURITY NO. 1  | 17. INF  | PRMANT The Med                                      |                   |                                | ess          |                |                        |
| (14      | No. or unknown) (If yes, give wor or d  | lates of service)       |                        |          | Clinical Co   |                   |                                |              | Marmela        | ha                     |
| =        | 18. CAUSE OF DEATH [Enter only  | one couse per li        |                        | THE      | OTTITUEL OF   | sirver ,          | ne oriende                     | 144.9        | INTERVAL       |                        |
|          | PART I. DEATH WAS CAUSE   | D BY:                   | 1. transage            | .0       | 1 Lemante   | NDI.              |                                |              | ONSET AN       | VD DEATH               |
|          | 2043 IMMEDIATE CA   | OUE TO                  | in your even           | var      | Joerna  | my                |                                |              | 1              | fus                    |
|          | Canditians, if any, which )   | DUE TO                  | a. t. L.               |          | 1 ti  | 6 1               |                                |              | 1 1            | un .                   |
|          | gave rise to immediate  | (b)                     | ann n                  | ym       | mayer   | Leun              | errice                         |              |                | 70                     |
|          | lying cause last.   | OUE TO                  |                        |          |   |                   |                                |              |                |                        |
| z        | PART II. OTHER SIGNIFICAN   | (c)                     | CONTRIBUTING TO DEATH  | BUT NO   | OT DELATED TO THE TERM                              | INIAI DISCASE     | CONDITIONICIN                  | TAL INI DART | 1/a) 10 W/A    | VSCALITODEV            |
| PICATION |   |                         |                        |          |   |                   |                                | EN IN PARI   | PER            | REFORMED?              |
| L CERTIF | 200. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF D<br>(IF EITHER, NOTIFY MEDICAL EXAM | DEATH<br>INER) 206. DES | CRIBE HOW INJURY OCCU  | JRRED. ( | Enter nature af injury in                           | Port I ar Part II | l af item 18.)                 |              |                |                        |
| MEDICA   | 20c. TIME OF INJURY Manth, Da<br>Haur a. m.<br>p. m.  | While                   |                        | foctor   | OF INJURY (Home, farm y, street, office bldg., etc. | n, 20f. (City a   | r tawn)                        | (Co          | ounty)         | (Stote)                |
|          | 21. I certify that I attended   | d the deceas            | ed from August         | 23       | 19 59 to Se   | eptembe           | r 2719 59                      | that I le    | ast saw th     | e decenses             |
|          | alive an September  | 27 195                  |                        |          | ccurred at 8:10                                     | PM fram           | the course of                  | nd an th     | a data st      | stad shave             |
|          | 0   |                         | and mor de             |          |   |                   | et, city or town,              |              |                | DATE SIGNED            |
| Ш        | ACTUAL SIGNATURE Colling  | RAZ                     | There an MI            | 1        | The Clin  | nical C           | enter                          |              |                |                        |
|          | SIGNATURE - D - SOOT  |                         | - COVA GEST /          | M.       | Nationa   |                   |                                | Heal         | th             |                        |
|          | PHYSICIAN'S Arthur R.   | Rothma                  | m, M.D.                |          | Bethesda  |                   |                                | 110002.      | . 022          |                        |
| 220      | BURIAL, CREMATION, 226. DATE 1  | HEREOF                  | 22c. NAME OF CEMETER   | Y OR C   |   |                   | DN (City, tawn, a              | r county)    | 15             | tate)                  |
|          | TOUND OCT   | : 1,1959                | Name of the last       |          |   |                   | Aalt                           | m.,          |                | 2.                     |
| 23,      | FUNERAL DIRECTOR'S SIGNATURE  | 13. 11                  | ADDRESS                | -, 1 6   | 24g. REC  | D BY REGISTRA     | R 24b. REGIS                   | TRAR'S SIGN  |                |                        |
| Y        | v. W Chambers   | 10, 1                   | Wast                   | 2        | C. DATE   |                   | - 0                            | hilling of   | e. tr.         |                        |
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|                             | MARYLAND S | TATE DEPARTM | ENT OF HEALTH-BALTIMO  | ORE, 18         |
|-----------------------------|------------|--------------|--|-----------------|
|                             | 10537      | CERTIFICA    | ATE OF DEATH   | R               |
| 1. PLACE OF DEATH a. COUNTY | 14         | MARYIAND     | 2. USUAL RESIDENCE (Where deceased lived.<br>a. STATE Marriel and b. | If institution: |

Reg. Dist. No. 10519

| 1. PLACE OF DEATH a. COUNTY                   |  |                            | a STATE                           | here deceased lived. If institution b. COUNTY |                                |
|---|--|----------------------------|-----------------------------------|---|--------------------------------|
|   | Montgomery   | MARYLAND                   | Mary                              | and   | Montgomery                     |
| RURAL and give n                              |  | c. LENGTH OF STAY IN 16    |                                   | autside corporate limits, write R             | URAL and give nearest tawn)    |
| Beth  |  | 7 days 11 hr               | .d. STREET ADDRESS                | )n  | e. IS RESIDENC                 |
| OR INSTITUTION                                | TAL (If not in haspital, give street                                 |                            | II /                              | LT Ctmoot                                     | ON A FARM                      |
|   | Suburban Hospi   | .tal                       | 10511 Wheat                       | tley Street                                   | YES NO                         |
| 3. NAME OF<br>DECEASED<br>(Type or print)     | First<br>Janis   | Middle                     | lost                              | 4. DATE Mon                                   |                                |
|   |  |                            | Zvirbolis                         | -   | IF UNDER 1 YEAR IF UNDER 24 H  |
| S. SEX  | 6. COLOR OR RACE 7. MARE   | DIVORCED                   | April 16, 18                      | 9. AGE (In years last birthday) 72 yrs.       | Manths Days Haurs Min          |
| 100 USUAL OCCUPATI                            | ON (Give kind af wark dane 10b.                                      |                            |                                   |   | 12. CITIZEN OF WHAT COUNT      |
| during most of war                            | rking life, even if retired)   |                            | Totario                           | a later great and many                        | Latvia L                       |
|   | penter Su  | burban Trust               | 14. MOTHER'S MAIDEN I             | NAME.   |                                |
| 13. FATHER'S NAME                             |  |                            | 14. MOTHER S MAIDEN I             |   |                                |
| Carl Zvir                                     |  |                            |                                   | Unknown                                       |                                |
| 1S. WAS DECEASED EVI<br>(Yes, no, or unknown) | ER IN U. S. ARMED FORCES? 16. (If yes, give war or dates of service) | SOCIAL SECURITY NO.        | INFORMANT (Daugh                  | ter) Add                                      |                                |
| No  |  | 9-46-0058 V                | ija Boniewic                      | Z   | As above                       |
| 18. CAUSE OF DE                               | ATH [Enter only one cause per li                                     | ne far (a), (b), and (c).] |                                   |   | INTERVAL BETWEEN               |
| PART I. DE.                                   | ATH WAS CAUSED BY:   | 21 N = C 11 -C             | .0:1                              | and in  | ONSET AND DEAT                 |
| 1,000   | IMMEDIATE CAUSE (a)  | To the Chirac              |                                   |   | 1                              |
| 400,0   | DUE TO   | 1                          | 0 00 11                           | 2. A.   |                                |
| Canditions, if a                              |  | le leins d                 | chouse +                          | ab clip                                       | en year                        |
| cause (a), stating                            | DILETO   |                            |                                   |   |                                |
| lying cause last.                             | _ (~)  |                            |                                   |   |                                |
| Z PART II. OT                                 | THER SIGNIFICANT CONDITIONS  | CONTRIBUTING TO DEATH BU   | T NOT RELATED TO THE TERM         | INAL DISEASE CONDITION GIV                    | VEN IN PART 1(a) 19. WAS AUTOF |
| PART II. OT                                   |  |                            |                                   |   | YES NO                         |
| T 20- ACCIDENT VA                             | 'AS UNDERLYING   20b. DES  | CRIBE HOW INJURY OCCURR    | ED. (Enter nature of injury in    | Part I ar Part II af item 18.)                |                                |
| OR CONTRIBUTING                               | G CAUSE OF DEATH Y MEDICAL EXAMINER)                                 |                            |                                   |   |                                |
|   |  | NUMBER 200 P               | LACE OF INJURY (Hame, farm        | m, 20f. (City ar tawn)                        | (Caunty) (St                   |
| Y 20c. TIME OF INJU<br>Haur a. m.<br>p. m.    | While  |                            | actary, street, affice bldg., etc |   | (Cdolliy) (Si                  |
| p. m.   | 19 at wor  |                            |                                   | / .   |                                |
| 21. I certify to                              | hat I attended the deceas  | ed from Alex               | 9 1959 to                         | Kent. 16, 1959                                | that I last saw the decea      |
| alive an -                                    | 817 15 10.   | -12                        | h accurred at 3 3 %               | M from the couses on                          | d an the date stated abo       |
| dilve dil                                     |  | on a second                | h decorred dillaring              | ADDRESS (Street, city or town,                |                                |
| ACTUAL &                                      | 150 1.10   | 11. 12.                    | Daglassi                          | 11. M   | 9/11/                          |
| SIGNATURE W                                   | C D Service  | a spendig                  | MD. KOCKY                         | ille, Maryla                                  | na                             |
| PHYSICIAN'S G                                 | . Beoditch Hu  | nter, Jr.                  |                                   |   |                                |
| 22a. BURIAL, CREMATIO                         |  | 22c. NAME OF CEMETERY      | OR CREMATORY                      | 22d. LOCATION (City, tawn,                    | ar caunty) (State)             |
| REMOVAL (Specify                              | 9/19/59  |                            |                                   |   |                                |
| DULTAL  | -//  | Parklawn (                 |                                   | Rockville,                                    | Mary Land<br>STRAR'S SIGNATURE |
| 23. FUNERAL DIRECTOR                          |  |                            |                                   |   | ribur & Krama                  |
| Robert A.                                     | . Pumphrev B   | ethesda. Mar               | VIANU DATE S                      | FP 1 JJ U                                     | VANAMA TI' A ARMAN             |

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| 40.211         | True or a refunded.         | Robert A. Pharlivey Principle |